GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GEORGIA FAMILIES PROGRAM

ANALYSES OF CLAIMS

SUBMITTED BY HOSPITALS TO GEORGIA CARE MANAGEMENT ORGANIZATIONS

FINAL DRAFT - JULY 17, 2008

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Certified Public Accountants

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GLOSSARY

These terms and references are used throughout this report:

- ***Adjudicate*** – A determination by the Care Management Organization of the outcome of a health care claim submitted by a health care provider. Claims may pay, deny, or in some cases have an alternative adjudication outcome.

- ***Ambulatory Surgical Center (ASC)*** – A health care service location in which surgical procedures are the primary focus of care.

- ***Appeal*** – A formal process whereby a health care provider requests that a payor review the outcome of a claim previously submitted to the payor for reimbursement. This term is typically reserved for claims that were originally denied for payment or paid at a lower amount by the payor, and the provider believes a payment should be made or paid at a higher amount.

- ***Capitation Claim*** - A per Medicaid and/or PeachCare for Kids™ member fixed payment amount made by DCH to a care management organization in return for the administration and provision of health care services rendered to the enrolled Medicaid and/or PeachCare for Kids™ member.

- ***Care Management Organization (CMO)*** – A private organization that has entered into a risk-based contractual arrangement with DCH to obtain and finance care for enrolled Medicaid or PeachCare for Kids™ members. CMOs receive a per capita or capitation claim payment from DCH for each enrolled member.

- ***Centers for Medicare and Medicaid Services (CMS)*** – The federal agency under the Department of Health and Human Services responsible for the oversight and administration of the federal Medicare program, state Medicaid programs, and State Children's Health Insurance Programs.

- ***Centers for Medicare and Medicaid Services 1500 (CMS-1500 or "1500") Claim Form*** – Document most often required by payors to be utilized by physicians and other non-institutional providers for submission of a claim request for reimbursement to the health care payor.

- ***Claims Processing System*** – A computer system or set of systems that determine the reimbursement amount for services billed by the health care provider.

- ***Clean Claim*** – A claim received by the CMO for adjudication in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment or alteration by the health care service provider in

order to be processed and paid by the CMO. Per the DCH CMO model contract, the following exceptions apply: 1) A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; 2) A Claim for which Fraud is suspected; and 3) A Claim for which a Third Party Resource should be responsible.

- ***Current Procedural Terminology (CPT) Codes*** – A listing of five character alphanumeric codes for use in reporting medical services and procedures performed by health care providers. CPT codes generally begin with a numeric character.

- ***Denied Claim*** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be ineligible for payment under the terms of the contract between the health care provider and payor.

- ***Explanation of Benefits (EOB)*** – A statement from a payor to a patient and/or health care provider that includes information detailing the pricing and adjudication of a fee-for-service claim and/or claim detail.

- ***Georgia Families (GF)*** – The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ where the Department contracts with Care Management Organizations to manage the care of eligible members.

- ***Fee-For-Service (FFS)*** – A health care delivery system in which a health care provider receives a specific reimbursement amount from the payor for each health care service provided to a patient.

- ***Fee-For-Service (FFS) Claim*** - A document, either paper or electronic, from a health care provider detailing health care services. Claims are submitted to a payor by a health care provider after a service has been provided to a patient covered by the payor. In some cases, the service must be authorized in advance. A FFS claim consists of one or more line items that detail all specific health care service(s) provided.

- ***Filing Time Limit*** – The maximum amount of time a provider can utilize to submit a claim to a health plan.

- ***Health Care Common Procedure Coding System Level II Codes (HCPCS Codes)*** – A listing of five character alphanumeric codes for use in reporting medical services, supplies, devices, and drugs utilized by health care providers.

- ***Medicaid Management Information System (MMIS)*** – Claims processing system used by the Department's fiscal agent claims processing vendor to process Georgia Medicaid and PeachCare for Kids™ FFS claims and capitation claims.

- ***Outpatient Services*** – Medical procedures, surgeries, or tests that are done in a qualified medical center without the need for an overnight stay.

- ***Paid Claim*** – A claim submitted by a health care provider for reimbursement that is deemed by the payor to be eligible for payment under the terms of the contract between the health care provider and payor.

- ***Payor*** – An entity that reimburses a health care provider a portion or the entire health care expenses of a patient for whom the entity is financially responsible.

- ***PeachCare for Kids™ Program (PeachCare)*** – The Georgia DCH's State Children's Health Insurance Program (SCHIP) funded by Title XXI of the Social Security Act, as amended.

- ***Prior Authorization (Authorization, PA, or Pre-Certification)*** – An approval given by a health care payor to a health care provider before a health care service is performed, that allows the provider to perform a specific health care service for a patient who is the financial responsibility of the payor with the understanding that the payor will reimburse the provider for the service.

- ***Provider Number (or Provider Billing Number)*** – An alphanumeric code utilized by health care payors to identify providers for billing, payment, and reporting purposes.

- ***Recoupment*** – Repayment of an overpayment, either by a payment from the provider or an amount withheld from the payment on a claim.

- ***Remittance Advice (RA)*** – A document provided by a health care payor to a health care provider that lists health care claims billed by the provider to the payor and explains the payment (or denial) of those claims.

- ***Revenue Codes*** – A listing of three digit numeric codes utilized by institutional health care providers to report a specific room (e.g. emergency room), service (e.g. therapy), or location of a service (e.g. clinic).

- ***Triage*** – The process of reviewing a patient's condition to determine the medical priority and the need for emergency treatment.

- ***Triage Rate*** – The reimbursement rate paid to a provider when a patient enters the emergency room but is deemed to not be in need of emergency care.

- ***Uniform Billing (UB or UB-92 or UB-04) Claim Form*** – Document most often required by payors to be utilized by hospitals and other institutional providers for submission of a claim request for reimbursement to the health care payor. The UB-92 version of the claim form was replaced by the UB-04 version in 2007. CMS refers to the UB-92/UB-04 claim form as the CMS-1450 claim form.

EXECUTIVE SUMMARY

In July 2005, the Georgia Department of Community Health (DCH or Department) contracted with AMERIGROUP Community Care (AMGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare), (hereinafter referenced as "CMOs") to provide health care services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, health care providers, and patients to work proactively to improve the health status of Georgia's Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving health care services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

Following the implementation of the Georgia Families (GF) program, hospitals and other providers began reporting negative experiences with the Georgia Families care management program. In particular, providers reported concerns with claims adjudication by the care management organizations (CMO). These concerns were reported to the CMOs, the Department of Community Health, members of the Georgia General Assembly, the Office of the Governor, and to the hospital and other provider industry associations.

DCH engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. The initial phase of the engagement includes an analysis of hospital related issues, claims payment and denial issues, and a review of certain GF and CMO policies and procedures.

The scope of this report is the analyses of the Georgia Families Program hospital claims experience and supporting processes such as the length of time required to load hospital contract terms into the CMOs' claims adjudication systems and to complete provider credentialing. DCH developed the scope of these analyses considering the issues and concerns raised by the hospital provider industry.

DCH requested that we analyze and report our findings by CMO and by provider group. The first provider group is for the Children's Healthcare of Atlanta (CHOA) hospitals that, for purposes of these analyses included the Egleston and Scottish Rite campuses. We analyzed CHOA claims data with incurred dates of service from June 1, 2006 through August 31, 2007. The second provider group is all other hospitals that included claims with incurred dates of service from December 1, 2006 through August 31, 2007. The analyses included inpatient and outpatient hospital claims.

In consultation with the Department of Community Health, we analyzed the data and documentation received from the CMOs. We did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was "accurate, complete, and truthful, and [was] consistent with the ethics statements and policies of DCH."

SUMMARY OF FINDINGS

For reference, the following claim counts for each CMO were received and utilized in our analysis. These claims include inpatient and outpatient hospital claims.

	CHOA[1]		Non-CHOA Hospitals[2]	
	Claims	**Percent**	**Claims**	**Percent**
AMGP Paid Claims	29,447	82.13%	146,906	92.28%
AMGP Denied Claims	6,376	17.78%	11,840	7.44%
AMGP Suspended Claims[3]	32	0.09%	443	0.28%
SubTotal	**35,855**	**100.00%**	**159,189**	**100.00%**
PSHP Paid Claims	59,491	82.22%	231,462	79.91%
PSHP Denied Claims	12,840	17.75%	56,428	19.48%
PSHP Suspended Claims[3]	24	0.03%	1,753	0.61%
SubTotal	**72,355**	**100.00%**	**289,643**	**100.00%**
WellCare Paid Claims	42,865	64.83%	393,306	64.53%
WellCare Denied Claims	6,844	10.35%	79,020	12.96%
WellCare Suspended Claims[3]	16,415	24.82%	137,164	22.50%
SubTotal	**66,124**	**100.00%**	**609,490**	**100.00%**

1) CHOA totals represent a distinct claim count for claims paid or denied between 6/1/2006 and 8/31/2007.
2) Non-CHOA hospital totals represent a distinct claim count of claims paid or denied between 12/1/2006 and 8/31/2007.
3) The CMOs were unable to provide a historical file of claims suspended and later processed for payment or denial. The suspended claim totals above represent a snapshot provided by the CMO of all claims in suspense status at the time the data file was extracted.

A summary of findings for the nine analyses completed on the above inpatient and outpatient hospital claims for CHOA and non-CHOA hospitals follows. The DCH and individual CMO responses to these findings are included in Exhibits 10 through 13.

ANALYSIS I: LENGTH OF TIME REQUIRED TO LOAD HOSPITAL CONTRACT TERMS

Please refer to Analysis I in the full report and Exhibit 1 for additional details regarding this analysis.

AMERIGROUP Community Care (AMGP)

- *CHOA* - The average number of days between CHOA's effective date as an in-network hospital and AMGP entering the provider's effective date into the AMGP claims payment system was 49 days.

- *Non-CHOA Hospitals* - Approximately 95 percent of non-CHOA hospital contracts were entered after their effective date with an average of 48 days between the effective date of the contract and the date the contract was loaded in the claims system.

Peach State Health Plan (PSHP)

- *CHOA* - Contract terms were entered into the claims system prior to the effective date of CHOA's in-network provider status.

- *Non-CHOA Hospitals* - Approximately 37 percent of non-CHOA hospital contracts were entered after their effective date with an average of 71 days between the effective date of the contract and the date the contract was entered into the claims system.

WellCare of Georgia (WellCare)

- *CHOA* - contracts were entered into WellCare's claims system 86 days after the dates they became effective as participating hospital providers.

- *Non-CHOA Hospitals* - Approximately 47 percent of non-CHOA hospital contracts were entered after their effective date with an average of 46 days between the effective date of the contract and the date the contract terms were entered into the claims system.

ANALYSIS II. LENGTH OF TIME REQUIRED TO COMPLETE CREDENTIALING OF HOSPITAL PROVIDERS

Please refer to Analysis II in the full report and Exhibit 2 for additional details regarding this analysis.

In the case of hospital providers, credentialing typically involves confirmation of Joint Commission on Accreditation Healthcare Organization (JCAHO) status, confirmation of licensure status, and obtaining copies of licenses, certificates, and insurance coverage.

AMGP
The data and information provided by AMGP regarding the dates that providers completed and submitted the credentialing application, and the date that the provider was credentialed were incomplete. Therefore, we were not able to analyze the timeliness of AMGP's credentialing process for any hospital providers based on the data provided. AMGP submitted additional information after the review period; however, this information was not analyzed.

PSHP
- *CHOA* - The amount of time that lapsed between the application date and the credentialing date for the Egleston facility was 36 days. For the Scottish Rite facility, PSHP reported that the application date and credentialing date were the same date (6/1/06) as the effective date of in-network provider status.

- *Non-CHOA Hospitals* - Approximately 48 percent of non-CHOA hospital providers were credentialed after the effective date of the contract, the average number of days between the application and credentialing date was 108 days.

WellCare
- *CHOA* - According to the data provided by WellCare, both of the CHOA facilities were credentialed prior to their in-network provider status dates.

- *Non-CHOA Hospitals* – Approximately 13 percent of non-CHOA hospitals were credentialed after their effective dates, the average was 34 days before the credentialing process was reported as complete.

ANALYSIS III. HOSPITAL DENIED CLAIMS

Please refer to Analysis III in the full report and Exhibit 3 for additional details regarding this analysis.

AMGP
- *CHOA* - Approximately 18 percent of all claims submitted by CHOA to AMGP were denied and approximately 20 percent of the denials were later paid by AMGP within an average of 87 days. AMGP paid approximately $28,000 in interest related to these claims. More than 60 percent of CHOA's hospital claims were denied in the first three months of the program by AMGP.

- *Non-CHOA Hospitals* - At no time during the period analyzed did the denial rate rise above nine percent for non-CHOA hospital providers in the aggregate, though individual providers may have experienced claim denial rates greater than nine

percent. Of the claims denied by AMGP, approximately five percent were later re-adjudicated and paid. These payments occurred within 43 days, on average, and resulted in approximately $7,400 in interest payments made by AMGP to providers.

PSHP

- *CHOA* - More than 50 percent of CHOA's claims were denied in the first few months following implementation of the Georgia Families program. Of the nearly 13,000 CHOA claims that were denied, approximately 10 percent of the claims were re-adjudicated and paid within an average of 84 days after the denial and resulted in interest payments from PSHP to CHOA of approximately $68,500.

- *Non-CHOA Hospitals* - Non-CHOA hospital claims denials revealed an apparent upward trend in the percentage of claim denials from June through August 2007. In December 2006, approximately 12 percent of hospital claims were denied. The denial rate fluctuated from December 2006 to May 2007, and by August 2007 the denial rate increased to more than 33 percent, when one out of three hospital claims was denied. Of the more than 56,000 claims denied, about 11 percent were later re-adjudicated and paid in an average of 53 days. PSHP paid approximately $118,000 in interest related to these claims.

WellCare

- *CHOA* - Between June 2006 and December 2006, approximately 12 percent of CHOA's claims were denied by WellCare. In the month of December 2006, approximately 30 percent of the CHOA claims denied. Between January 2007 and August 2007, approximately 10 percent of the CHOA claims were denied. WellCare later paid about 15 percent of the claims originally denied. We calculated an average of 74 days between the original denial of a claim and the payment of the claim. We were unable to confirm that WellCare made interest payments to CHOA, or any other hospital providers, when they re-adjudicated a previously denied claim. WellCare submitted additional interest information after the review period; however, this information was not analyzed.

- *Non-CHOA Hospitals* - The analysis indicates that more than 15 percent of claims submitted by non-CHOA hospitals were denied each month. Approximately four percent of denied claims were later re-adjudicated and paid. The average length of time between the denial and payment was approximately 47 days. We could not confirm that WellCare made interest payments to these facilities.

ANALYSIS IV. HOSPITAL SUSPENDED CLAIMS

Please refer to Analysis IV in the full report and Exhibit 4 for additional details regarding this analysis.

We analyzed the suspended hospital claims files from the CMOs to identify trends or observations regarding the volume of suspended claims. It is important to note that our

findings from this analysis are based only on the volume of suspended claims at these specific points in time, which may not be indicative of historical levels of suspended claims by each CMO.

AMGP

- *CHOA* - As of July 1, 2007, AMGP had 32 suspended claims outstanding with charges of approximately $150,000. Each of the 32 outstanding suspended claims was suspended in June 2006. More than a year has passed from the date the claims originally suspended. According to the data, 58 percent of the suspend reason codes apparently relate to prior authorization issues.

  Based on the data submitted by AMGP, we were unable to determine how many of the more than 35,800 CHOA claims that ultimately adjudicated and paid or denied between June 2006 and August 2007 had originally been suspended.

- *Non-CHOA Hospitals* - As of July 1, 2007, there were more than 440 suspended claims outstanding for non-CHOA hospitals. Three hospitals, Grady Memorial Hospital, Medical College of GA and East Georgia Regional Medical Ctr, comprise approximately 25 percent of all suspended claims based on billed charges. All but two of the more than 440 outstanding suspended claims were suspended in June 2007. The data indicates that about 43 percent of the suspended reasons relate to prior authorization issues.

  Based on the data submitted by AMGP, we were unable to determine how many of the more than 158,000 non-CHOA claims that ultimately adjudicated and paid or denied between December 2006 and August 2007 had originally been suspended.

PSHP

- *CHOA* - As of September 1, 2007, PSHP had 24 suspended claims outstanding for CHOA. These 24 claims included services with charges of approximately $890,000. Fourteen of the 24 outstanding suspended claims were suspended in July 2007. These claims were suspended due to claims issues (e.g., possible duplicate), prior authorization issues, and provider set-up issues.

  Based on the data submitted by PSHP, we were unable to determine how many of the more than 69,000 CHOA claims that ultimately adjudicated and paid or denied between June 2006 and August 2007 had originally been suspended.

- *Non-CHOA Hospitals* - As of September 1, 2007, there were more than 1,750 suspended claims outstanding for non-CHOA hospitals. These claims totaled more than $6M in billed charges. Three hospitals, Phoebe Putney Memorial Hospital, Atlanta Medical Center - Tenet and Medical Center Inc, comprise approximately 31 percent of all suspended claims based on billed charges. Eighty-five percent of the outstanding suspended claims were suspended in June 2007. Approximately 75 percent of the suspense reason codes indicate a potential provider set-up issue.

Based on the data submitted by PSHP, we were unable to determine how many of the more than 274,000 non-CHOA claims that ultimately adjudicated and paid or denied between December 2006 and August 2007 had originally been suspended.

WellCare

- *CHOA* - As of November 1, 2007, WellCare had approximately 16,000 outstanding suspended CHOA claims with billed charges of more than $89.5M. Approximately 60 percent of the suspense reasons relate to prior authorization issues and about 18 percent were for potential duplicate claims.

  Based on the data submitted by WellCare, we were unable to determine how many of the more than 49,000 CHOA claims that ultimately adjudicated and paid or denied between June 2006 and August 2007 had originally been suspended.

- *Non-CHOA Hospitals* - As of November 1, 2007, more than 137,000 claims with approximately $447M of billed charges for non-CHOA hospitals remained suspended. More than $395M of those claims, based upon total billed charges, were suspended in September and October 2007. Fifty-five percent of the reason codes for all suspended claims indicate a prior authorization reason for the suspense.

  Based on the data submitted by WellCare, we were unable to determine how many of the more than 477,000 non-CHOA claims that ultimately adjudicated and paid or denied between December 2006 and August 2007 had originally been suspended.

ANALYSIS V. HOSPITAL CLAIMS ADJUDICATION

Please refer to Analysis V in the full report and Exhibit 5 for additional details regarding this analysis.

AMGP

- *CHOA* - Approximately 95 percent of the CHOA hospital claims, excluding suspended claims, were adjudicated within 15 days. AMGP paid interest of more than $164,000 on CHOA claims, including interest on claims that adjudicated within 15 days.

- *Non-CHOA Hospitals* - AMGP adjudicated approximately 96 percent of the non-CHOA hospital claims, excluding suspended claims, within 15 days, and 99 percent within 30 days. AMGP paid interest of more than $70,000 on non-CHOA hospital claims, including interest on claims that adjudicated within 15 days.

PSHP

- *CHOA* - Approximately 93 percent of CHOA hospital claims were adjudicated by PSHP within 15 days. PSHP paid interest of more than $96,000 to CHOA for claims adjudicated in 15 or more days.

- *Non-CHOA Hospitals* - Ninety-one percent of the non-CHOA hospital claims submitted to PSHP adjudicated within 15 days. PSHP paid more than $400,000 in interest for the claims that adjudicated in 15 or more days.

WellCare

- *CHOA* - Approximately 97 percent of the CHOA hospital claims were adjudicated within 15 days.

- *Non-CHOA Hospitals* - WellCare adjudicated approximately 99 percent of the non-CHOA hospital claims within 15 days. Since information regarding interest payments was not available during the time we were conducting our analysis, we are not able to comment regarding interest payments made by WellCare during the period being analyzed. WellCare submitted additional information after the review period and therefore, it was not analyzed.

ANALYSIS VI. GEORGIA FAMILIES PROGRAM PROVIDER RETENTION

Please refer to Analysis VI in the full report and Exhibit 6 for additional details regarding this analysis.

We analyzed the claims data and provider network information to determine whether any trends or potential provider retention concerns might exist for the Georgia Families program. We noted, across all CMO groups, no unexplained cases where claims submissions decreased to zero for hospital providers. A few providers have decreased claims submissions but these providers appear to still be participating with the health plans during the period analyzed.

ANALYSIS VII. HOSPITAL CLAIM DENIALS RELATED TO MEMBER ELIGIBILITY

Please refer to Analysis VII in the full report and Exhibit 7 for additional details regarding this analysis.

AMGP

- *CHOA* - We identified 513 CHOA hospital claims that were denied by AMGP due to member eligibility issues. Of the more than 500 claims denied, 80 claims or 16 percent were for members that according to DCH's fiscal agent were locked-in to AMGP during the time the denied service occurred.

- *Non-CHOA Hospitals* - 3,325 non-CHOA hospital claims were denied due to member eligibility issues. Of the more than 3,000 claims denied, 129 claims or four

percent were for members that according to DCH's fiscal agent were locked-in to AMGP during the time the denied service occurred.

PSHP

- *CHOA* - Over 1,500 CHOA claims were denied due to member eligibility issues. Of the more than 1,500 claims denied, 189 claims or 12 percent were for members that according to DCH's fiscal agent were locked-in to PSHP during the time the denied service occurred.

- *Non-CHOA Hospitals* - Over 7,700 non-CHOA hospital claims denied due to member eligibility issues. Of the more than 7,700 claims denied, 1,487 claims or 19 percent were for members that according to DCH's fiscal agent were locked-in to PSHP during the time the denied service occurred.

WellCare

- *CHOA* - Twelve CHOA hospital claims were denied due to reasons indicating the member was not eligible. Of the 12 claims denied, seven claims were for members that according to DCH's fiscal agent were locked-in to WellCare during the time the denied service occurred.

- *Non-CHOA Hospitals* - 292 non-CHOA hospital claims were denied due to reasons indicating the member was not eligible. Of the 292 claims denied, 272 claims or 93 percent were for members that according to DCH's fiscal agent were locked-in to WellCare during the time the denied service occurred.

ANALYSIS VIII. ACCURACY OF HOSPITAL PROVIDER RATES

Please refer to Analysis VIII in the full report and Exhibit 8 for additional details regarding this analysis.

AMGP

- *All Hospitals* - 14 outpatient hospital rates from 14 hospitals were loaded into the CMO's claims payment system incorrectly. Approximately 28,000 distinct claims through August 31, 2007 are potentially impacted by these rates.

PSHP

- *All Hospitals* - Five outpatient hospital rates from five hospitals were loaded into the CMO's claims payment system incorrectly. Approximately 11,000 outpatient hospital claims are potentially impacted by these rate issues.

WellCare

- *All Hospitals* - Our analysis of WellCare's rate files, claims data, and hospital contracts reveals no apparent differences between the contracted rates and the inpatient and outpatient hospital rates loaded into the system.

ANALYSIS IX. EMERGENCY ROOM VISITS PAID AT TRIAGE RATES

Please refer to Analysis IX in the full report and Exhibit 9 for additional details regarding this analysis.

We analyzed the emergency room reimbursement trends of each of the CMOs. For reference, a summary of the emergency room reimbursement methodology by CMO is included in the full version of our report. Based on claims data received from each CMO, our analyses sought to identify the frequency at which hospital emergency room claims are reimbursed at the triage rates when the claims were coded with CPT codes 99281, 99282, 99283, 99284 and 99285.

In an April 2000 letter to State Medicaid Directors, CMS advised that absent provider up-coding, CPT codes 99283 - 99285 "very likely" meet the federal prudent layperson standard of a true "emergency". The Georgia Families Program CMOs pay non-emergency visits to the ER at a contracted triage rate, usually $50, and claims for which the services are determined to be for a true "emergency" at a higher emergency rate as specified by the provider contract.

AMGP

- *CHOA* - Our analysis of the CHOA emergency room claims paid by AMGP indicates that 100 percent of all claims submitted with CPT codes 99283, 99284 or 99285 were paid at emergency rates. For CPT 99282, approximately 11 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal.

- *Non-CHOA Hospitals* - Emergency room claims data for AMGP non-CHOA hospital providers indicated that the frequency of triage rate payments for CPT codes 99283, 99284 and 99285 ranged from approximately 11 percent for CPT code 99283 to one percent for CPT code 99285. Approximately 1.5 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal.

PSHP

- *CHOA* - The results of our analysis of the CHOA emergency room claims paid by PSHP indicated that the frequency of triage rate payments for CPT codes 99283, 99284 and 99285 ranged from approximately 23 percent for CPT code 99283 to 11 percent for 99285. Approximately 58 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal.

- *Non-CHOA Hospitals* - Non-CHOA hospital provider data from PSHP indicated that the frequency of triage rate payments for CPT codes 99283, 99284 and 99285 ranged from approximately 12 percent for CPT code 99283 to three percent for CPT

code 99285. Approximately 42 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal.

WellCare

- *CHOA* - WellCare CHOA emergency room claims data shows that a significant number of the claims paid by WellCare with CPT codes 99283 – 99285 were reimbursed at the triage rate. Claims billed with CPT code 99283 were reimbursed the triage rate 76 percent of the time. Claims billed with CPT code 99285 were paid the triage rate in 44 percent of the cases. Approximately seven percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal.

- *Non-CHOA Hospitals* - Based on the claims data from WellCare, non-CHOA hospital providers receive the triage rate on 39 percent of all claims paid for CPT code 99283, 31 percent of claims paid for 99284, and 24 percent of claims paid for CPT code 99285. Approximately one percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal.

RECOMMENDATIONS

The Myers and Stauffer LC recommendations are included at the end of the full report. In addition to our recommendations, a summary of House Bill 1234 follows our recommendations.

House Bill 1234 was passed by the 2007-2008 Georgia General Assembly on April 4, 2008, and was signed into law by Governor Perdue on May 13, 2008. Many of the provisions of House Bill 1234 appear to address the observations, findings, and recommendations included in this report. In addition, the Department of Community Health has informed us that they have incorporated the provisions of House Bill 1234 and many of our recommendations into the most recent CMO contract.

BACKGROUND

In July 2005, the Georgia Department of Community Health (DCH or Department) contracted with AMERIGROUP Community Care (AMGP), Peach State Health Plan (PSHP) and WellCare of Georgia (WellCare), (hereinafter referenced as "CMOs") to provide health care services under the Georgia Families care management program. This risk-based managed care program is designed to bring together private health plans, health care providers, and patients to work proactively to improve the health status of Georgia's Medicaid and PeachCare for Kids™ members. Approximately 600,000 members in the Atlanta and Central regions of the state began receiving health care services through Georgia Families on June 1, 2006. Georgia Families was expanded statewide to the remaining four regions, and approximately 400,000 additional members, on September 1, 2006.

The objective of the Georgia Families program is to strengthen the state's health care system by allowing members the option of choosing a health plan that best suits their needs; providing health education and prevention programs; and assisting members find doctors and specialists when necessary. When participating in the Georgia Families program, members are assigned a primary care provider, in part, to establish a medical home and to improve continuity and coordination of care.

Under the Georgia Families program, Medicaid and PeachCare For Kids™ members are eligible for many of the same health care services they received under the traditional fee-for-service Medicaid and PeachCare For Kids™ programs. They may also be eligible for additional services offered by the care management organizations.

DCH's contract with the CMOs delineates the requirements to which each CMO must adhere, which are summarized below.

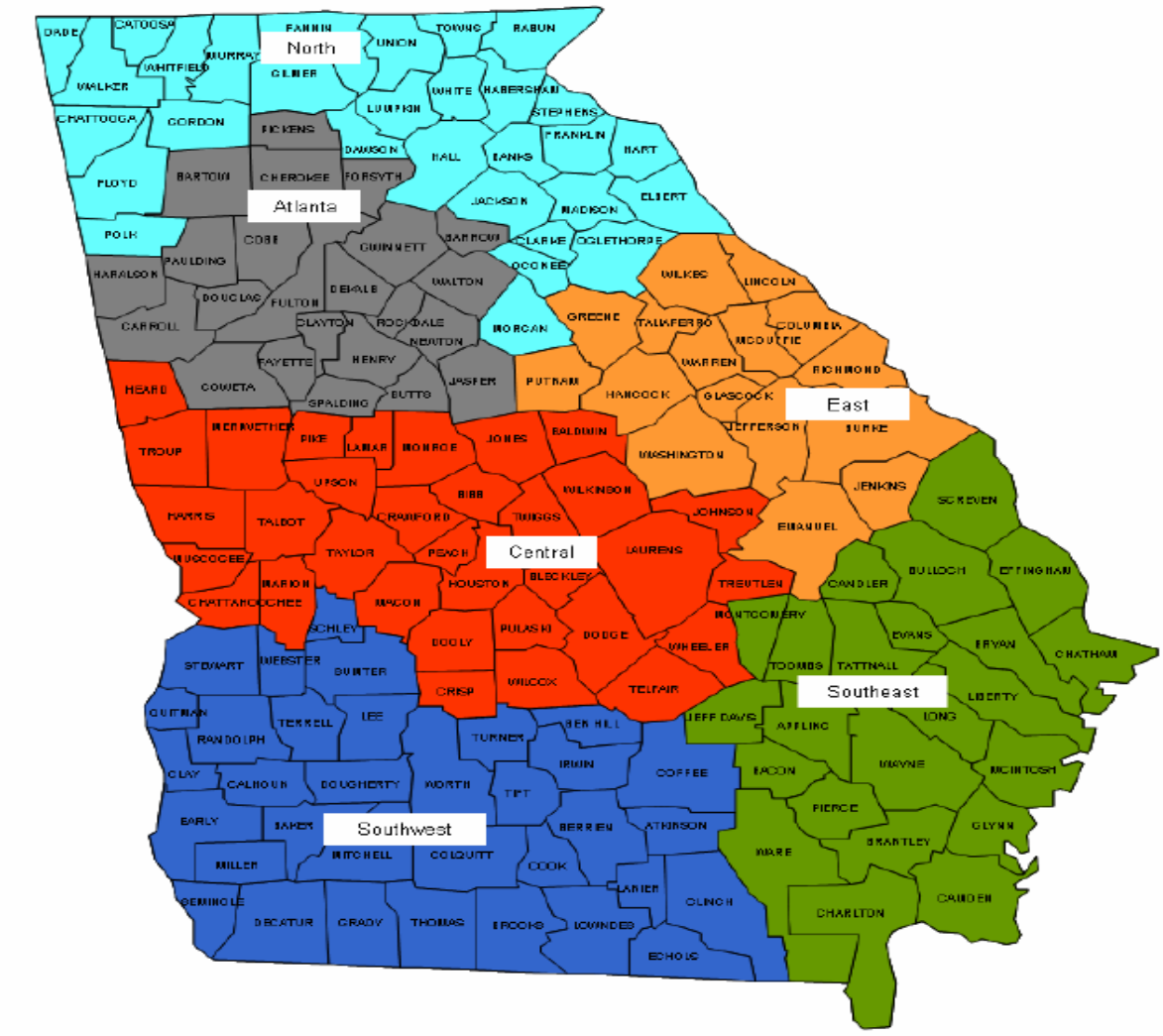
- The covered benefits and services that must be provided to the Medicaid and PeachCare For Kids™ members.
- The provider network and service requirements for the CMOs.
- Medicaid and PeachCare For Kids™ enrollment and disenrollment requirements.
- Allowed and disallowed marketing activities.
- General provider contracting provisions.
- Quality improvement guidance.
- Reporting requirements and other areas of responsibility.

In return for the CMOs satisfying the terms of the contract, the Department pays each CMO a monthly capitation payment for each enrolled Medicaid and PeachCare For Kids™ member, as well as kick payments for newborns.

The table below illustrates the participation of the three CMOs by coverage region.

Region	AMGP	PSHP	WellCare
Atlanta	√	√	√
Central		√	√
East	√		√
North	√		√
Southeast	√		√
Southwest		√	√

The chart below includes an illustration of the Georgia Families coverage regions.



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As noted, each coverage region has at least two CMOs participating, while the Atlanta region includes all three plans.

Within each region, a participating CMO is required to build a network of health care providers sufficient to provide access to necessary services for its members. CMOs and providers develop contractual relationships, negotiating payment rates specific to each CMO and provider. Generally, CMOs reimburse hospitals with which they contract at rates that are a negotiated percentage above the Medicaid fee-for-service payment structure. The contracts between a CMO and its other non-hospital network providers are generally structured in a similar manner, with the exception of the negotiated payment rates, which typically vary by provider type. Some policy variations may also exist in the various contracts between CMOs and providers. For example, contracts may differ among plans and providers on the number of days a provider has to file a claim for reimbursement after a health care service is provided. Contracts between the CMO and provider are generally effective for one year with subsequent automatic renewals. Contracts typically may be terminated by either party upon receipt of a written notice if terminated for reasons other than a breach of contract.

PROJECT PURPOSE

Following the implementation by DCH of the Georgia Families program, hospitals and other providers began reporting negative experiences with the Georgia Families care management program. In particular, providers reported concerns with claims adjudication by the CMOs. These concerns were reported to the CMOs, the Department of Community Health, members of the Georgia General Assembly, the Office of the Governor, and to the hospital and other provider industry associations.

In part due to these provider concerns, the Department of Community Health engaged Myers and Stauffer LC to study and report on specific aspects of the GF program, including certain issues presented by providers, selected claims paid or denied by CMOs, and selected GF policies and procedures. The initial phase of the engagement includes an analysis of hospital related issues, claims payment and denial issues, and a review of certain GF and CMO policies and procedures. Subsequent phases of the engagement will include similar reviews related to other provider categories.

SCOPE OF REPORT

The scope of this report is the analyses of the Georgia Families Program hospital claims experience and supporting processes such as the length of time required to load hospital contract terms into the CMOs' claims adjudication systems and to complete the provider credentialing. The Department of Community Health developed the scope of these analyses considering the issues and concerns raised by the hospital provider industry. This report provides the results of these data analyses.

Other reports regarding hospital providers and claim experience, including an analysis of Georgia Families Program policies and procedures will be issued at a later date. You may also refer to our prior report of Georgia Families Hospital Issues and Concerns dated January 14, 2008. This report is available on the DCH's website at http://dch.georgia.gov/00/channel_title/0,2094,31446711_102898636,00.html.

METHODOLOGY

The Department of Community Health requested that we analyze and report our findings by Care Management Organization and by provider group. The first provider group is for the Children's Healthcare of Atlanta (CHOA) hospitals that, for purposes of these analyses included the Egleston and Scottish Rite campuses. The Egleston and Scottish Rite facilities are reported collectively as the "CHOA" facility. We analyzed CHOA claims data from the beginning of the Georgia Families Program, which included claims with incurred dates of service from June 1, 2006 through August 31, 2007. The second provider group is all other hospitals, except for CHOA. For all other hospitals, we analyzed claims with incurred dates of service from December 1, 2006 through August 31, 2007. The analyses included inpatient and outpatient hospital claims billed on the UB claim form.

Myers and Stauffer LC requested from each CMO a list of claims data and related documentation needed for this initiative on September 18, 2007. We requested from the CMOs specific payment terms for each hospital, including each hospital contract and any subsequent contract amendments. The due date of the data and documentation was October 12, 2007. Following receipt of the requested information, we worked closely with the CMOs to address questions regarding the requested data, as well as to obtain clarification and additional information deemed necessary for our analysis. All hospital related data and documentation was received from the CMOs by the end of December 2007. Also, in response to questions we asked of WellCare during the course of our analyses, WellCare resubmitted two additional files in March 2008 due to issues they identified with the data originally submitted. All claims and associated reference data was loaded onto our secure SQL Server environment for our analysis and review.

In consultation with the Department of Community Health, we analyzed the data and documentation received from the CMOs, and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was "accurate, complete, and truthful, and [was] consistent with the ethics statements and policies of DCH".

The following analyses are included:

Analysis I: Length of Time Required to Load Hospital Contract Terms – We analyzed the timeliness of loading into the CMOs' claims processing system the contractual payment terms for each participating hospital provider.

Analysis II: Length of Time Required to Complete Credentialing of Hospital Providers – We analyzed the timeliness of the hospital provider credentialing process by the CMOs.

Analysis III: Hospital Denied Claims – We performed analyses of the hospital claims data to identify claim denial trends.

Analysis IV: Hospital Suspended Claims – We analyzed the suspended hospital claims files from the CMOs to identify trends or observations regarding the volume of suspended claims.

Analysis V: Hospital Claims Adjudication Analyses – We performed various analyses of the claims data to determine the timing of claims adjudication for each CMO.

Analysis VI: Georgia Families Program Provider Retention – We analyzed the claims data and provider network information to determine whether any trends or potential provider retention concerns might exist for the Georgia Families program.

Analysis VII: Hospital Claim Denials Related to Member Eligibility – We analyzed the claims denied by the CMOs for issues related to member eligibility. We compared claims to the member lock-in file from DCH in an attempt to determine the volume of claims denied for issues related to member eligibility.

Analysis VIII: Accuracy of Hospital Provider Rates – We analyzed the accuracy with which the three CMOs loaded provider reimbursement rates into their claims payment systems.

Analysis IX: Emergency Room Visits Paid at Triage Rates – We analyzed the emergency room reimbursement trends of each of the CMOs.

For reference, the following claim counts for each CMO were received for analysis. These claims include inpatient and outpatient hospital claims.

	CHOA[1]		Non-CHOA Hospitals[2]	
	Claims	**Percent**	**Claims**	**Percent**
AMGP Paid Claims	29,447	82.13%	146,906	92.28%
AMGP Denied Claims	6,376	17.78%	11,840	7.44%
AMGP Suspended Claims[3]	32	0.09%	443	0.28%
SubTotal	**35,855**	**100.00%**	**159,189**	**100.00%**
PSHP Paid Claims	59,491	82.22%	231,462	79.91%
PSHP Denied Claims	12,840	17.75%	56,428	19.48%
PSHP Suspended Claims[3]	24	0.03%	1,753	0.61%
SubTotal	**72,355**	**100.00%**	**289,643**	**100.00%**
WellCare Paid Claims	42,865	64.83%	393,306	64.53%
WellCare Denied Claims	6,844	10.35%	79,020	12.96%
WellCare Suspended Claims[3]	16,415	24.82%	137,164	22.50%
SubTotal	**66,124**	**100.00%**	**609,490**	**100.00%**

1) CHOA totals represent a distinct claim count for claims paid or denied between 6/1/2006 and 8/31/2007.
2) Non-CHOA hospital totals represent a distinct claim count of claims paid or denied between 12/1/2006 and 8/31/2007.
3) The CMOs were unable to provide a historical file of claims suspended and later processed for payment or denial. The suspended claim totals above represent a snapshot provided by the CMO of all claims in suspense status at the time the data file was extracted.

ASSUMPTIONS AND LIMITATIONS

The assumptions and limitations summarized below should be noted when reviewing this report.

- In consultation with the Department of Community Health, we analyzed the data and documentation received from the CMOs, and we did not independently validate or verify the information. Each CMO attested and warranted that the information they provided was "accurate, complete, and truthful, and [was] consistent with the ethics statements and policies of DCH".

- The information provided by the CMOs contains hospital claims with dates of service through August 31, 2007. The data was provided to Myers and Stauffer by the CMOs between October and December 2007 (except for two corrected files submitted by WellCare in March 2008 in response to questions we asked them regarding the data). All trends and information identified in the data may be limited since we cannot determine whether changes have been made in policy, pricing, adjudication, or whether claims have been adjusted or reprocessed subsequent to our receipt of this data.

ANALYTICAL SUMMARIES AND FINDINGS

The results of our analyses follow. Additional reports and information can be found in the Exhibits to this report. The DCH and individual CMO responses to these findings are included in Exhibits 10 through 13.

ANALYSIS I: LENGTH OF TIME REQUIRED TO LOAD HOSPITAL CONTRACT TERMS

DCH requested that Myers and Stauffer analyze the hospital provider contracting process of the three CMOs, including whether the contractual payment terms for each participating hospital provider were loaded into the CMOs' claims processing system in a timely manner. We performed various tests of the claims data in an effort to identify the length of time necessary to load contract terms, including the analysis of paid and denied hospital claims, an analysis of each hospital contract, and an analysis of an electronic hospital rate file submitted by each CMO.

We studied the following key data components:

- CMO-reported effective dates of each hospital provider's in-network status.
- Date the CMO entered the hospital's in-network status into their system.
- First date that a claim was received from a hospital.
- First date of service for which a claim was filed by a hospital regardless of whether the claim paid, suspended or denied.
- Date of the first paid claim.

When comparing the specific dates reported by the CMO in the claims data files to the contracts between the CMOs and hospitals, we note the following:

- In some instances, it appears that the date reported by the CMO as the effective date of the provider's in-network status could be the last date that a contract amendment or renewal was executed.

- For all three CMOs, we noted a number of instances where the effective date of a hospital's status as an in-network provider was after the date of service of the first claim submitted by the hospital.

- In some instances, the effective date of in-network status reported by the CMO was not the same as the effective date stated in the contract.

- Some contract effective dates were prior to the date that DCH implemented the Georgia Families program in a particular area.

- Some hospital providers may have submitted claims for services that were provided before their effective date as a participating provider with a particular CMO.

For additional information regarding the findings discussed below, please refer to Exhibit 1.

FINDINGS

AMGP – CHOA Only, Exhibit 1a

The data provided by AMGP indicates that the average number of days between CHOA's effective date as an in-network hospital and AMGP entering the provider's effective date into the AMGP claims payment system was 49 days.

AMGP – All Other Non-CHOA Hospital Providers, Exhibit 1b

The data provided by AMGP indicated that approximately five percent of participating hospital's contracts were entered into AMGP's claims payment system prior to the effective date of the provider's in-network status. For those hospital providers that did not have their contract entered prior to this date, the average was 48 days between the effective date of the contract and the date the contract was loaded in the claims system.

PSHP – CHOA Only, Exhibit 1c

The data provided by PSHP indicates that PSHP loaded CHOA contract terms into their claims system prior to the effective date of CHOA's in-network provider status.

PSHP – All Other Non-CHOA Hospital Providers, Exhibit 1d

The data provided by PSHP indicates that approximately 63 percent of the participating hospital providers had their contracts entered into PSHP's claims system prior to their effective date of their in-network provider status. For those hospital providers that were not entered into the claims system prior to their effective date, an average of 71 days passed between the effective date of the contract and the date the contract was entered into the claims system. However, the date that the hospital provider's contract was entered into PSHP's claims system was blank for 36 hospitals. The data for these providers is not included in the above completion percentages.

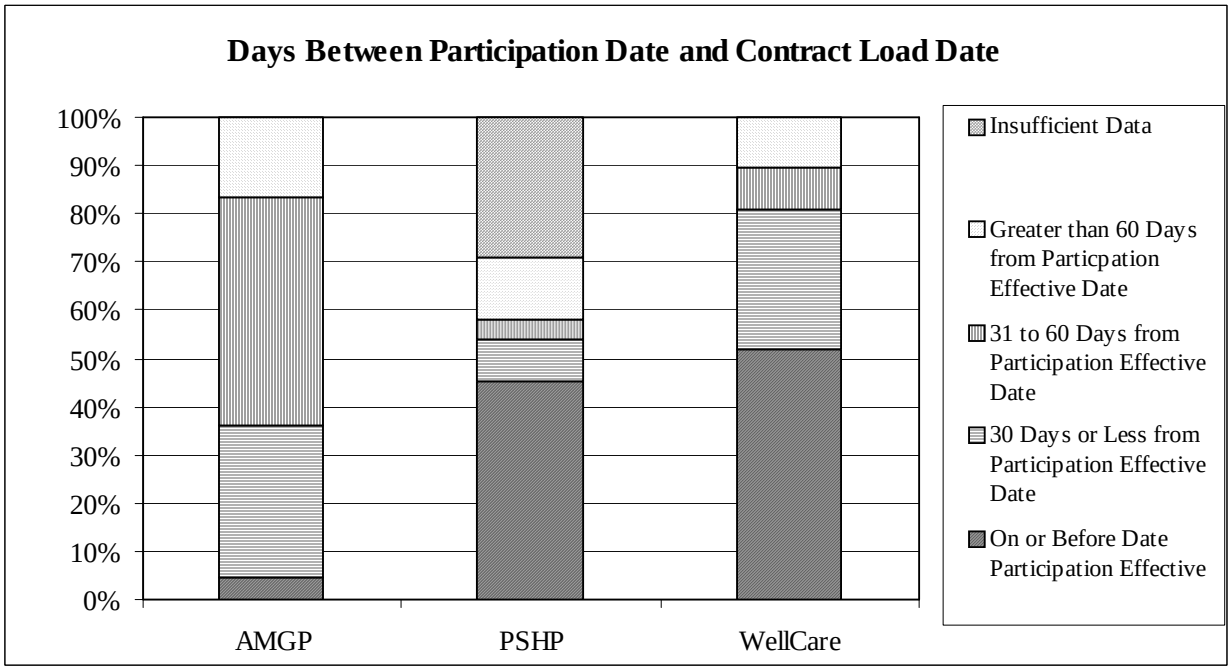
WellCare – CHOA Only, Exhibit 1e

The data provided by WellCare indicates that the CHOA contracts were entered into WellCare's claims system after the dates they became effective as participating hospital providers. Both CHOA facilities' contracts were entered 86 days after the effective date of the contract. The dates provided by WellCare may represent the date that the CHOA contracts were either amended or renewed, rather than the initial effective date of in-network status.

WellCare – All Other Non-CHOA Hospital Providers, Exhibit 1f

The data provided by WellCare indicates approximately 53 percent of the participating hospital provider's contracts were entered into WellCare's claims system prior to the effective date of the hospital's in-network provider status. For those hospitals that were not entered prior to their effective date, there was an average of 46 days between the effective date of their contract and the date the contract terms were entered into the claims system.

The following chart illustrates and summaries the number of days required to load hospital contracts into the CMOs' claims processing system.



ANALYSIS II: LENGTH OF TIME REQUIRED TO COMPLETE CREDENTIALING OF HOSPITAL PROVIDERS

DCH requested that Myers and Stauffer analyze the length of time for the CMOs to complete the provider credentialing process. Credentialing of hospital providers differs from the credentialing process for rendering physicians and practitioners. In the case of hospital providers, credentialing typically involves confirmation of Joint Commission on Accreditation Healthcare Organization (JCAHO) status, confirmation of licensure status, and obtaining copies of licenses, certificates, and insurance coverage. PSHP and WellCare reported to us a date that credentialing was completed. The information received from AMGP was insufficient and therefore analysis could not be completed for AMGP. AMGP submitted additional information after the review period; therefore, this information was not analyzed.

We performed various tests of the claims data in an effort to identify trends associated with the amount of time required for each CMO to credential hospital providers. In many cases, the information regarding the application or credentialing date was not provided by the CMO and is reflected accordingly in the Exhibits. Averages computed based on the application and credentialing dates do not include the providers for which the appropriate dates were not provided. Please also refer to Exhibit 2 for more detailed information regarding this analysis.

FINDINGS

AMGP - CHOA and All Other Non-CHOA Providers – Please refer to Exhibits 2a and 2b

The data and information provided by AMGP regarding the dates that providers completed and submitted the credentialing application, and the date that the provider was credentialed were incomplete. Therefore, we were not able to analyze the timeliness of AMGP's credentialing process for any hospital providers based on the data provided. As indicated above, AMGP did submit additional information after the review period. However, this information was not analyzed.

PSHP – CHOA Only - Please refer to Exhibit 2c

Based on the data provided by PSHP, both of the CHOA hospital facilities were credentialed on the same date that their status as an in-network provider with PSHP was effective (6/1/06). We noted that the amount of time that lapsed between the application date and the credentialing date for the Egleston facility was 36 days. For the Scottish Rite facility, PSHP reported that the application date and credentialing date were the same date (6/1/06) as the effective date of in-network provider status.

PSHP – All Other Non-CHOA Providers - Please refer to Exhibit 2d

Based on the information provided by PSHP, approximately 52 percent of the providers for which data was supplied were credentialed prior to the effective date of their in-network status. It is important to note that PSHP did not provide information for a large

number of providers, with the exception of the In-Network status date. Of the remaining 48 percent of providers who were credentialed after the effective date, the average number of days between the application and credentialing date was 108 days. Overall, for this group of hospital providers for which PSHP provided complete information, the credentialing process required an average of 58 days from application date to completion of the credentialing process.

WellCare - CHOA Only – Please refer to Exhibit 2e

According to the data provided by WellCare, both of the CHOA facilities were credentialed prior to their in-network provider status dates. WellCare did not provide the dates that the provider completed the application process and as a result we are not able to draw conclusions about the credentialing timeliness for these two hospitals.

WellCare – All Other Non-CHOA Providers – Please refer to Exhibit 2f

Analysis of the data provided by WellCare indicated that approximately 87 percent of hospital providers (excluding the CHOA facilities) were credentialed prior to the effective date of in-network status. Of the remaining 13 percent that were credentialed after their effective dates, the average was 34 days before the credentialing process was reported as complete. WellCare did not provide the dates that the hospitals completed the application process and we not able to analyze the timeliness of their credentialing process.

ANALYSIS III: HOSPITAL DENIED CLAIMS

DCH requested that Myers and Stauffer analyze hospital claims denied for payment by the three CMOs. We performed various tests of the claims data in an effort to identify any trends or utilization issues.

The information resulting from the various claims denial analyses includes the following:

1) ***Denied claims per month*** – The information in this analysis shows the number of denied hospital claims posted each month.
2) ***Denied claims as a percentage of total adjudicated (i.e., paid and denied) claims per month*** – This analysis illustrates denied claims for each CMO and compares the denied claims totals to the total number of adjudicated claims
3) ***Top denial reason categories and number of denied claims for these categories*** – We analyzed all denial reason codes based on the volume of denials for each code.
4) ***Number of denied claims that were later paid*** – We completed an analysis of denied claims that were later re-adjudicated and paid, either at the request of the provider or due to a CMO-initiated adjustment process.
5) ***Average length of time between denial and subsequent payment*** – This analysis includes information showing the number of claims that were initially denied but were later paid, and the average length of time between the denial of a claim and the subsequent payment of that same claim.
6) ***Amount and number of interest payments*** – This information includes the total dollar volume and the number of interest payments made by each CMO to hospital providers for previously denied claims.

Please also refer to Exhibit 3 for additional information regarding these analyses. *Note that none of the figures in this analysis incorporate suspended claims since the suspended claims files we received were a snapshot of claims suspended at a point in time.*

FINDINGS

AMGP - CHOA Only – Please Refer to Exhibit 3a

We analyzed fifteen months of CHOA claims data from AMGP. Over that fifteen-month period, approximately 18 percent of all claims submitted by CHOA to AMGP were denied. Approximately 20 percent of the denials (or a little more than three percent of all AMGP CHOA claims) were later paid by AMGP within an average of 87 days. AMGP paid approximately $28,000 in interest related to these claims.

We noted that the volume of denials was greatest in the first few months following the implementation of Georgia Families. More than 60 percent of CHOA's hospital claims were denied in the first three months of the program by AMGP. Subsequently, the denial rate fell rapidly, but we observed a spike in claim denials for CHOA at Egleston in January 2007, when 30 percent of their claims were denied. We also observed that the

denial rate for CHOA at Scottish Rite spiked in March 2007, when 20 percent of their claims were denied, then the denial rate generally decreased for both hospital locations. As of August 2007, the denial rate was about 10 percent or less for both CHOA facilities.

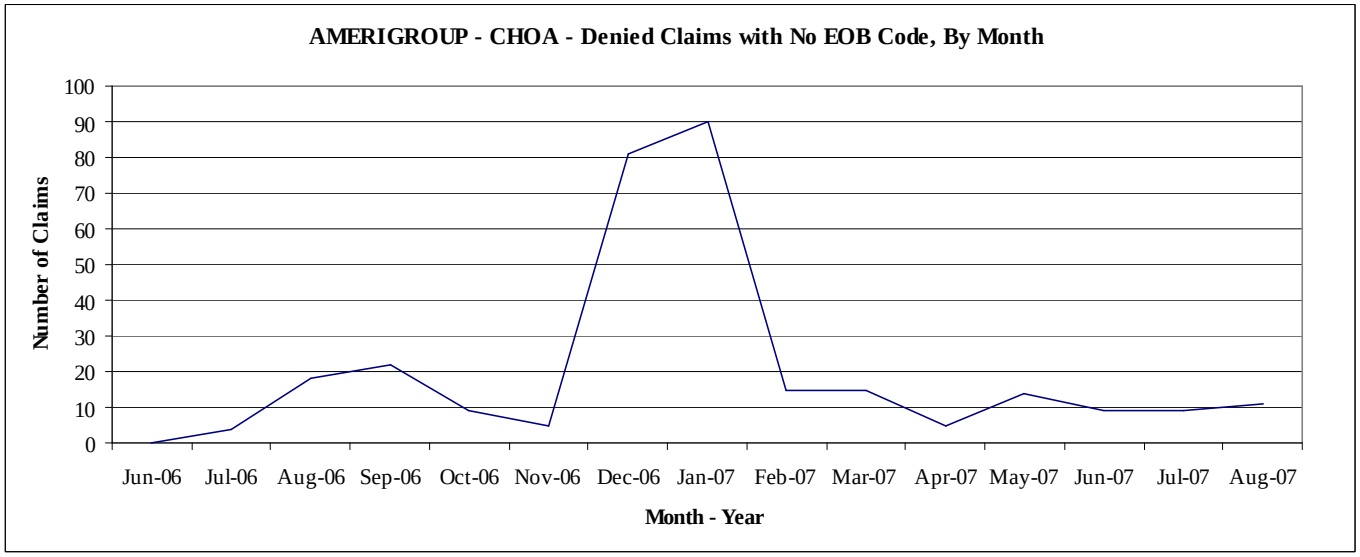
We also analyzed the denial reasons. We found that 37 percent of the denial codes CHOA received during this fifteen-month period stated that the claim was a duplicate claim. These denials could be due to several reasons, including at least:

- Resubmission of claims due to lack of receipt of payment from the CMO for a previously submitted claim.
- Resubmission of claims due to receipt of payment from the CMO that the provider believed was inaccurate.
- Resubmission of claims due to provider error.

In addition to the duplicate claims, we observed:

- 20 percent of the denial reason codes indicate that the claim had an issue with the revenue code/procedure code combination.
- 18 percent of the denial codes indicated an issue existed with the timely filing of the claim.
- Five percent of the claim denials were due to prior authorization issues.

Approximately four percent of the claims included a denial with no denial reason code (i.e., EOB Code). We further analyzed these claims, and have included an illustration below, showing the volume of AMGP claim denials over the fifteen months of claims data we analyzed.



It appears that the spike in denials having no EOB coincides with the increase in denials during that period previously mentioned.

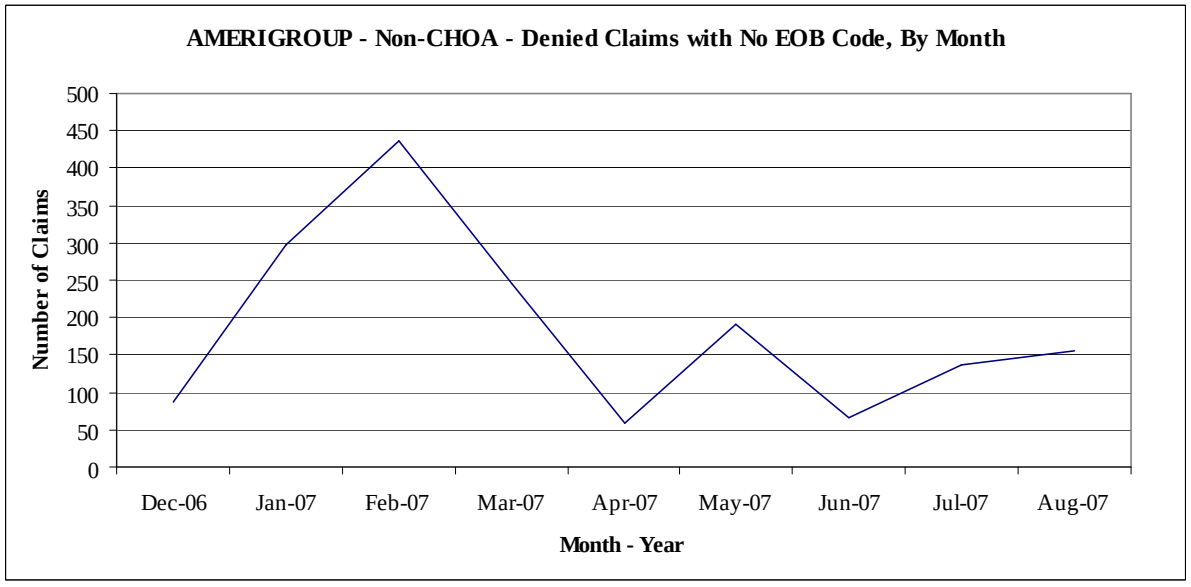
The remaining denials were for other reasons, including denials that indicate, “Billing Error”, “Deny per Medical Director”, “Deny All Claim Lines”, “Inappropriate billing for this contract”, and other reasons. Please note that a claim may have more than one denial reason code. Please refer to Exhibit 3a for additional detail regarding the denial reason codes and the volume of these codes.

AMGP - Non-CHOA Hospitals – Please Refer to Exhibit 3b

We analyzed AMGP’s non-CHOA hospital claims denials for claims with dates of service between December 1, 2006 and August 31, 2007. At no time during this period did the denial rate rise above nine percent for these hospital providers in the aggregate, though individual providers may have experienced claim denial rates greater than nine percent during this period.

Of the claims denied by AMGP, approximately five percent (less than one percent of total claims) were later re-adjudicated and paid. These payments occurred within 43 days, on average, and resulted in approximately $7,400 in interest payments made by AMGP to providers.

During our analysis of denial reason codes, we noted that more than 11 percent of claim denial reasons were blank. We analyzed these claim denials by month, which are illustrated in the following graph. Please note that a claim may have more than one denial reason code. Please also refer to Exhibit 3b for additional detail regarding the denial reason codes and the volume of these codes.



PSHP - CHOA Only – Please Refer to Exhibit 3c

We analyzed fifteen months of PSHP claims for the two CHOA hospitals. We noted that more than 50 percent of CHOA's claims were denied in the first few months following implementation of the Georgia Families program. While these denial rates dropped dramatically thereafter, by August 2007 the denial rates again increased to approximately 19 percent.

Of the nearly 13,000 CHOA claims that were denied, approximately 10 percent of the claims (about two percent of total claims) were re-adjudicated and paid at a later time. The average number of days to pay the claim after denial was 84 days and resulted in interest payments from PSHP to CHOA of approximately $68,500.

Our analysis of the PSHP denial reason codes for CHOA hospitals reveals the following. It should be noted that a claim may have more than one denial reason code.

- Approximately 30 percent of the denials were for duplicate claims.
- About 24 percent of denials were due to revenue code / HCPCS code combination issues.
- About nine percent of denials were due to the member not being eligible for coverage.
- Approximately seven percent of denials were due to no prior authorization for the service.

Please refer to Exhibit 3c for additional detail regarding the denial reason codes and the volume of these codes.

PSHP - Non-CHOA Hospitals – Please Refer to Exhibit 3d

Our analysis of PSHP non-CHOA hospital claims denials revealed an apparent upward trend in the percentage of claim denials from June through August 2007. In December 2006, approximately 12 percent of hospital claims were denied. It should be noted that individual providers may have experienced claim denial rates in excess of 12 percent during this period. The denial rate fluctuated from December 2006 to May 2007, and by August 2007 the denial rate increased to more than 33 percent, when one out of three hospital claims was denied.

Of the more than 56,000 claims denied, about 11 percent (two percent of total claims) were later re-adjudicated and paid in an average of 53 days. PSHP paid approximately $118,000 in interest related to these claims.

While analyzing the denial reason codes, we noted that 16 percent of denial reasons that posted indicated that the provider had no national provider identification number (NPI) on file, or the provider did not bill with their NPI. Approximately 30 percent of the denial reason codes were related to duplicate claim submissions. More than seven percent of the denial reason codes that posted to claims indicate that the service was not covered. Approximately seven percent of the denial reasons related to the

timeliness of the claim filing, another seven percent indicated that the member did not have coverage at the time of the service, and about five percent of denials indicated that there was no prior authorization for the service. Please note that a claim may have more than one denial reason code. Please refer to Exhibit 3d for additional detail regarding the denial reason codes and the volume of these codes.

WellCare - CHOA Only – Please Refer to Exhibit 3e

The volume of claims denied by WellCare for CHOA was fairly consistent over the fifteen-month period we analyzed, with the exception of December 2006. Between June 2006 and December 2006, about 12 percent of CHOA's claims were denied by WellCare. In the month of December 2006, approximately 30 percent of the CHOA claims denied. Of the claims denied in December, 26 percent of the denials appear to be due to duplicate submission and 22 percent denied due to prior authorization issues. The remaining denial reasons were "Payment adjusted because the payer deems the information submitted does not support this level of service" (13 percent), "This service/equipment/drug is not covered under the patients current benefit plan" (six percent), and various other denial reason codes (33 percent).

After December 2006, the denial rate decreased. Between January 2007 and August 2007, approximately 10 percent of the CHOA claims were denied. WellCare later paid about 15 percent of the claims originally denied (equal to approximately two percent of the total WellCare paid and denied claims for CHOA). We calculated an average of 74 days between the original denial of a claim and the payment of the claim. However, the claims file information that we received from WellCare does not include interest payments; therefore, we were unable to confirm that WellCare made interest payments to CHOA, or any other hospital providers, when they re-adjudicated a previously denied claim. WellCare submitted additional information after the review period; therefore, this information was not analyzed.

Approximately 30 percent of CHOA's denials were the result of no prior authorization for the service. More than 26 percent of denial codes indicate the claim was a duplicate claim. The remaining denial reasons include invalid claim information (18 percent); Fee, Service Limit, or Charge Issue (16 percent); and various other issues (10 percent). Please note that a claim may have more than one denial reason code. Please refer to Exhibit 3e for additional detail regarding the denial reason codes and the volume of these codes.

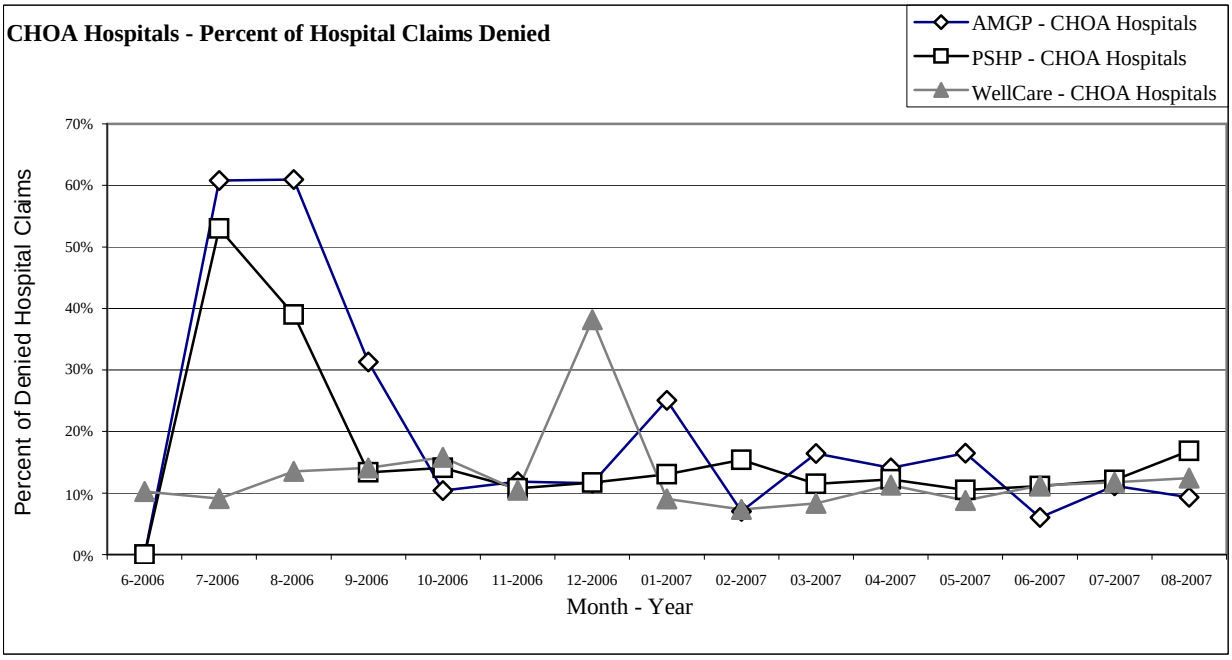
WellCare - Non-CHOA Hospitals – Please Refer to Exhibit 3f

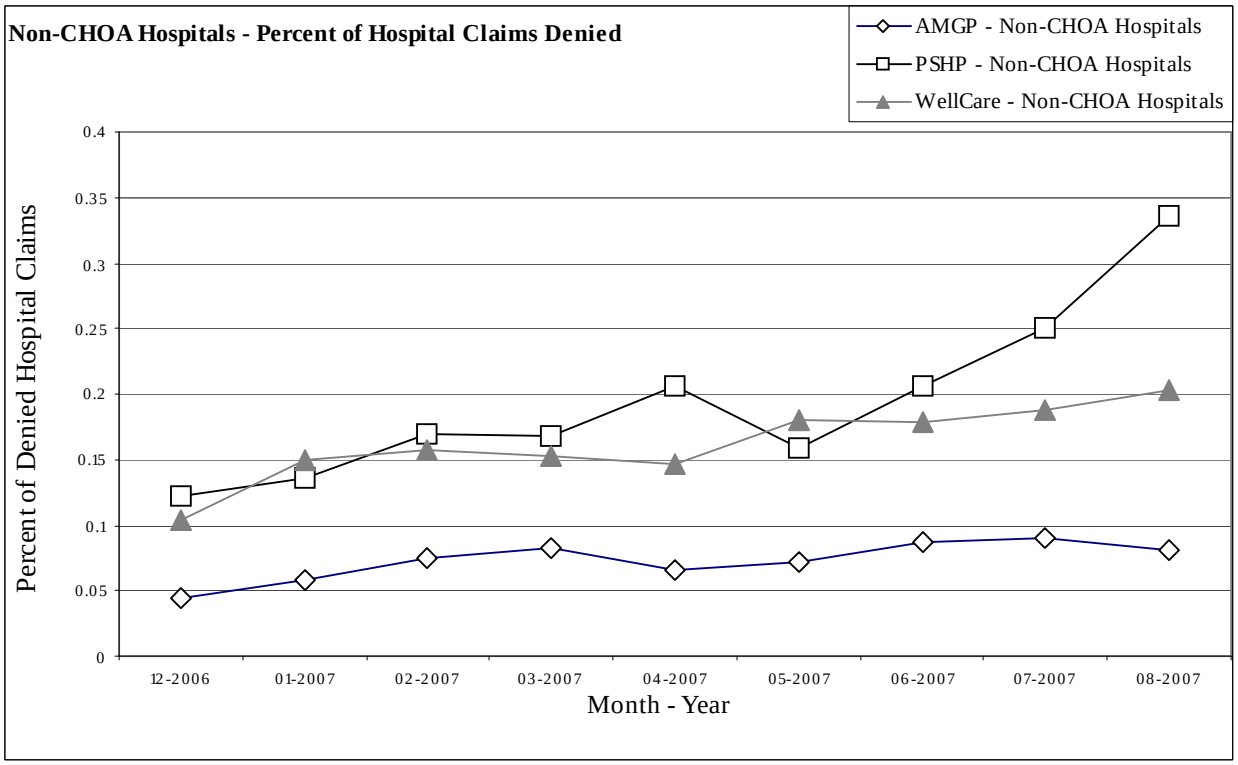
The analysis appears to indicate that more than 15 percent of claims submitted by non-CHOA hospitals were denied each month. Approximately four percent of denied claims (about one percent of total paid and denied claims) were later re-adjudicated and paid. The average length of time between the denial and payment was approximately 47 days. We could not confirm that WellCare made interest payments to these facilities.

The claim denial rate fluctuated over the analysis period. In April 2007, the denial rate was below 15 percent. By August 2007 the denial rate increased to more than 20

percent. Approximately 28 percent of the denied claims were due to a procedure not being on the provider's fee schedule or the procedure not being covered. Twenty-five percent of the denial codes indicate prior authorization issues. The remaining denial reasons include Fee, Service Limit, or Charge Issue (18 percent); Incorrect/Invalid Information (13 percent); Duplicate Service (10 percent); and various other issues (six percent). Please note that a claim may have more than one denial reason code. Please refer to Exhibit 3f for additional detail regarding the denial reason codes and the volume of these codes.

The following charts illustrate a summary of denied claims as a percentage of total adjudicated claims by month and CMO.





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ANALYSIS IV: HOSPITAL SUSPENDED CLAIMS

DCH requested that Myers and Stauffer analyze the suspended claims volume of the three CMOs. We performed various tests of the claims data in an effort to identify apparent trends or utilization issues. Please note that the term "suspended" is sometimes also used interchangeably with the term "pended". The CMOs all reported to us that a historical suspended claims file was not available. However, they were able to provide to us a suspended claims file as of a particular point in time. Therefore, we requested that each CMO provide us with a file as of July 1, 2007 or the latest available date.

The data and analyses include claims suspended as of July 1, 2007 for AMGP, September 1, 2007 for PSHP, and November 1, 2007 for WellCare. It is important to note that our findings from this analysis are based only on the volume of suspended claims at these specific points in time, which may not be indicative of historical levels of suspended claims by each CMO.

The information resulting from the various claims denial analyses includes the following:

1) ***Suspended claims by provider*** – The information in this analysis shows the total number of suspended hospital claims posted as suspended for each hospital.
2) ***Suspended claims by month*** – This analysis displays the number of suspended claims for each CMO each month.
3) ***Suspended reason code analysis*** – We analyzed the reason codes on all suspended claims based on the volume of suspended claims for each code. Claims may have been suspended for multiple reasons, and for purposes of this analysis and the statistical data indicated below, we only considered the first reason code observed in the claim record.

FINDINGS

AMGP –CHOA Only – Please Refer to Exhibit 4a

We analyzed the AMGP suspended claims for two CHOA hospitals. As of July 1, 2007, AMGP had 32 suspended claims outstanding with charges of approximately $150,000. Each of the 32 claims was suspended in June 2006. More than a year has passed from the date the claims originally suspended.

According to the data from AMGP, 58 percent of the suspend reason codes for CHOA suspended claims relate to prior authorization issues. Of the remaining suspend reasons, no other code accounts for more than nine percent of the total.

Based on the data submitted by AMGP, we were unable to determine how many of the more than 35,800 CHOA claims that were ultimately adjudicated and paid or denied between June 2006 and August 2007 had originally been suspended.

AMGP – Non-CHOA Hospitals – Please Refer to Exhibit 4b

As of July 1, 2007, there were more than 440 suspended claims for non-CHOA hospitals. Three hospitals, Grady Memorial Hospital, Medical College of GA and East Georgia Regional Medical Ctr, comprise approximately 25 percent of all suspended claims based on billed charges. All but two of the more than 440 suspended claims outstanding were suspended in June 2007.

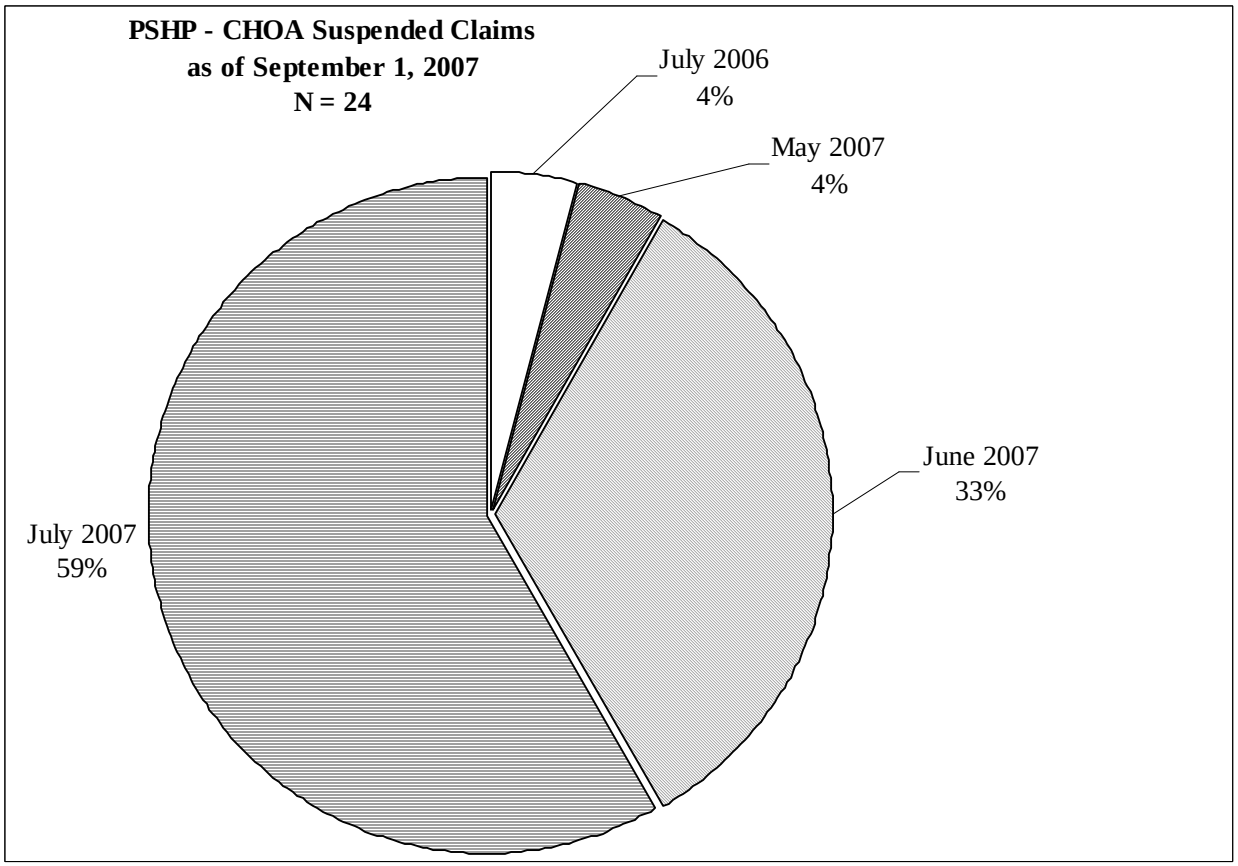
The data submitted by AMGP indicates that about 43 percent of the suspended reasons relate to prior authorization issues. Of the remaining suspend reasons, no other code accounts for more than nine percent of the total.

Based on the data submitted by AMGP, we were unable to determine how many of the more than 158,000 non-CHOA hospital claims that were ultimately adjudicated and paid or denied between December 2006 and August 2007 had originally been suspended.

PSHP – CHOA Only – Please Refer to Exhibit 4c

As of September 1, 2007, PSHP had 24 suspended claims outstanding for CHOA. These 24 claims included services with charges of approximately $890,000. Fourteen of the 24 claims were suspended in July 2007. These claims were suspended due to claims issues (e.g., possible duplicate), prior authorization issues, and provider set-up issues.

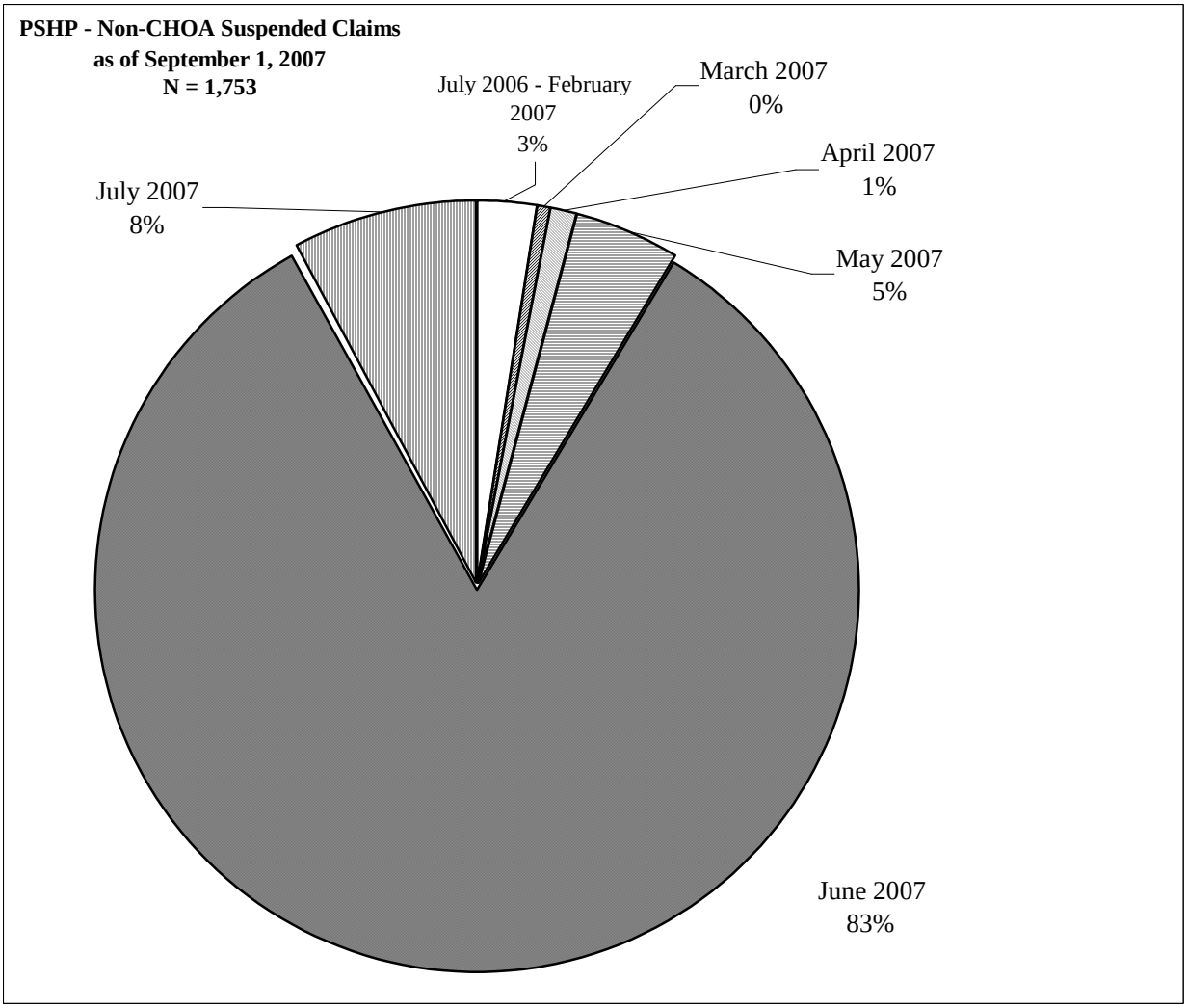
Based on the data submitted by PSHP, we were unable to determine how many of the more than 69,000 CHOA claims that were ultimately adjudicated and paid or denied between June 2006 and August 2007 had originally been suspended.



PSHP – Non-CHOA Hospitals – Please Refer to Exhibit 4d

As of September 1, 2007, there were more than 1,750 suspended claims outstanding for non-CHOA hospitals. These claims totaled more than $6M in billed charges. Three hospitals, Phoebe Putney Memorial Hospital, Atlanta Medical Center - Tenet and Medical Center Inc, comprise approximately 31 percent of all suspended claims based on billed charges. Eighty-five percent of the suspended claims were suspended in June 2007. Approximately 75 percent of the suspense reason codes indicate a potential provider set-up issue.

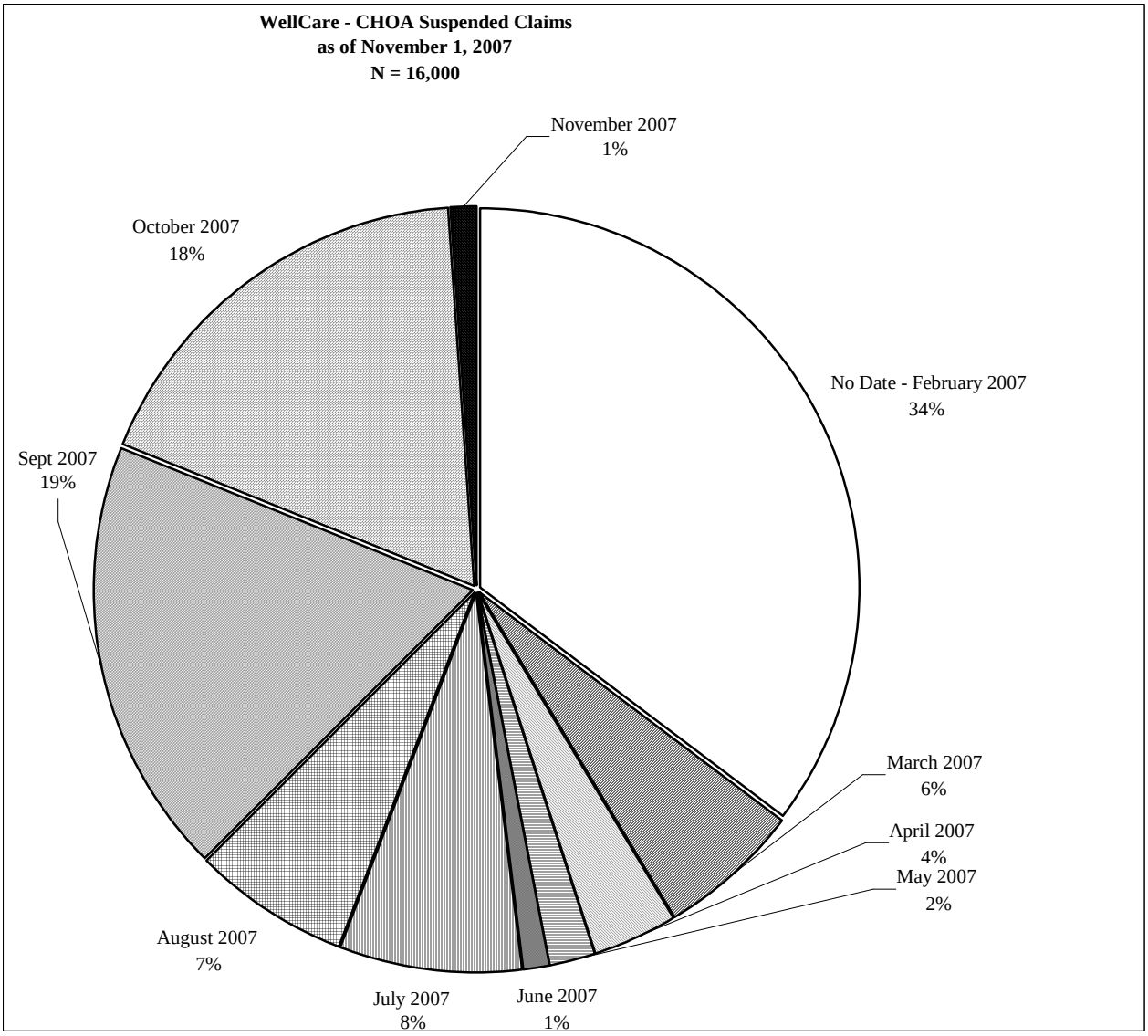
Based on the data submitted by PSHP, we were unable to determine how many of the more than 274,000 non-CHOA hospital claims that were ultimately adjudicated and paid or denied between December 2006 and August 2007 had originally been suspended.



WellCare – CHOA Only – Please Refer to Exhibit 4e

According to the suspended claims file provided by WellCare, as of November 1, 2007, WellCare had more than 16,000 outstanding suspended CHOA claims with billed charges of approximately $89.5M. Approximately one percent of these suspended claims had no apparent suspend date. The remaining claims were suspended between June 2006 and November 1, 2007. About 40 percent of the claims were suspended in September and October 2007. Approximately 60 percent of the suspense reasons relate to prior authorization issues and about 18 percent were for potential duplicate claims.

Based on the data submitted by WellCare, we were unable to determine how many of the more than 49,000 CHOA claims that were ultimately adjudicated and paid or denied between June 2006 and August 2007 had originally been suspended.



WellCare – Non-CHOA Hospitals – Please Refer to Exhibit 4f

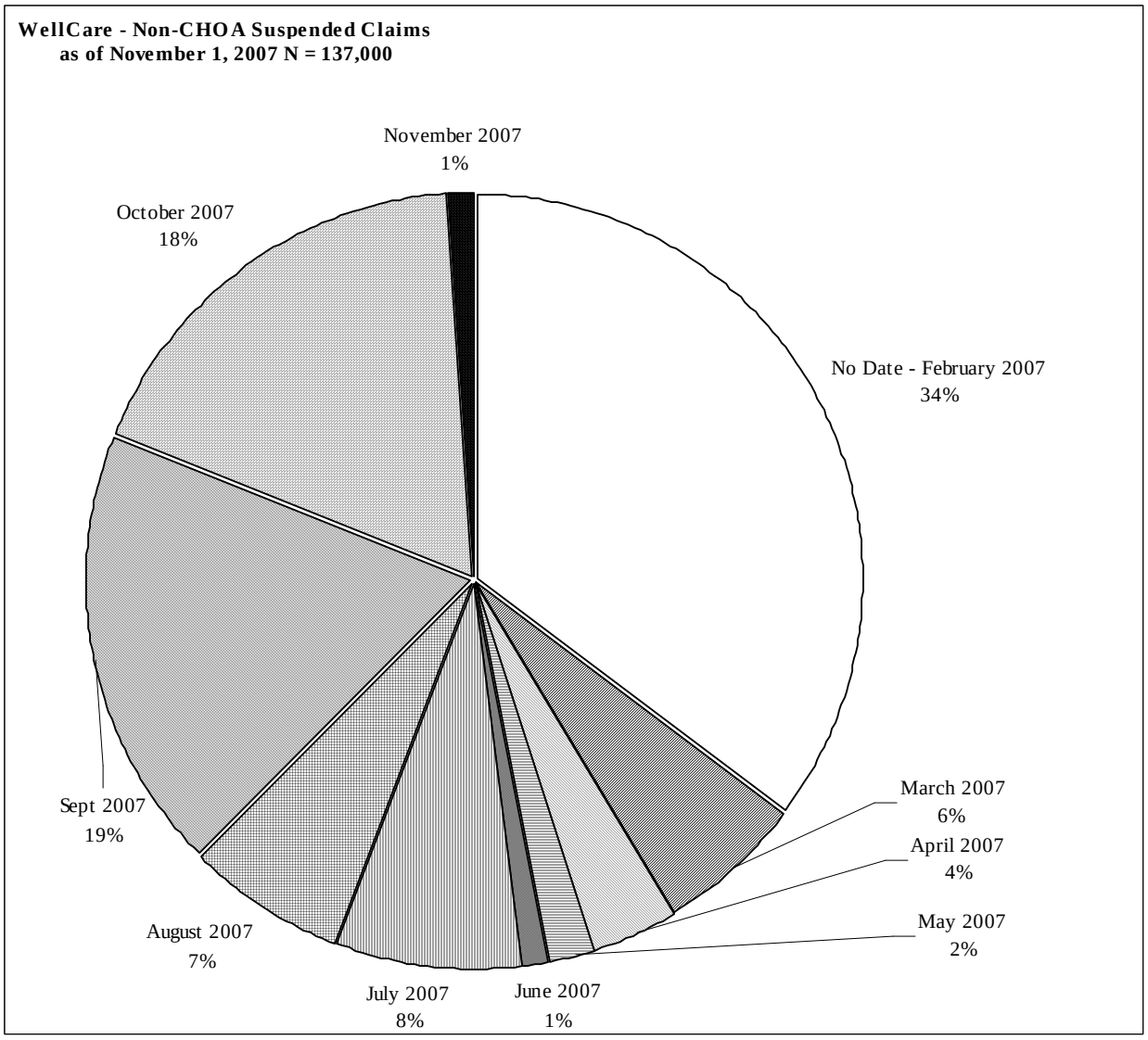
The suspended claims file from WellCare indicates that as of November 1, 2007, more than 137,000 claims with approximately $447M of billed charges remained suspended. The table below illustrates the top 25 providers based on total billed charges.

Provider Name	Claim Count	Billed Amount
MEDICAL CENTER OF CENTRAL GEORGIA	9,261	$23,922,924
THE MEDICAL CENTER	5,376	$21,845,429
TCT CHILDRENS HOSPITAL	855	$21,246,390
MEMORIAL HEALTH UNIVERSITY MED CTR	4,561	$21,009,523
MEDICAL COLLEGE OF GEORGIA	10,455	$19,229,471
GRADY MEMORIAL HOSPITAL	10,067	$17,215,236

Provider Name	Claim Count	Billed Amount
FLOYD MEDICAL CENTER	2,560	$15,819,212
ATLANTA MEDICAL CENTER	1,013	$14,471,834
NORTHSIDE HOSPITAL	1,647	$14,423,130
SOUTH FULTON MEDICAL CENTER	1,183	$13,719,751
WELLSTAR COBB HOSPITAL	2,997	$12,618,059
DOCTORS HOSPITAL	1,237	$10,363,675
ATHENS REGIONAL MEDICAL CENTER	3,065	$9,826,681
NORTHEAST GEORGIA MEDICAL CENTER	2,094	$9,494,922
GWINNETT MEDICAL CENTER	3,911	$9,295,869
KENNESTONE HOSPITAL	2,288	$8,691,399
SOUTHERN REGIONAL MED CTR	1,644	$7,555,770
EMORY UNIVERSITY HOSPITAL - MAIN	454	$7,367,193
UNIVERSITY HOSPITAL	1,472	$7,240,508
HOUSTON MEDICAL CENTER	2,612	$7,208,307
EMORY CRAWFORD LONG HOSPITAL	1,136	$6,961,280
SPALDING REGIONAL MEDICAL CENTER	1,066	$6,552,275
EAST GEORGIA REGIONAL MEDICAL CTR	1,149	$6,424,032
ROCKDALE MEDICAL CENTER	2,065	$6,357,293
CANDLER HOSPITAL	1,653	$6,193,779

More than $395M in claims, based upon total billed charges, were suspended in September and October 2007. Fifty-five percent of the reason codes for all suspended claims indicate a prior authorization reason for the suspense. The remaining claim suspense reasons consist of a variety of claim review reason codes including “potential duplicate.”

Based on the data submitted by WellCare, we were unable to determine how many of the more than 477,000 non-CHOA hospital claims that were ultimately adjudicated and paid or denied between December 2006 and August 2007 had originally been suspended.


WellCare - Non-CHOA Suspended Claims
as of November 1, 2007 N = 137,000
November 2007
1%
October 2007
18%
No Date - February 2007
34%
March 2007
6%
April 2007
4%
May 2007
2%
June 2007
1%
July 2007
8%
August 2007
7%
Sept 2007
19%

ANALYSIS V: HOSPITAL CLAIMS ADJUDICATION ANALYSES

DCH requested that Myers and Stauffer analyze the adjudicated claims of the three CMOs. We performed various tests of the claims data in an effort to identify any apparent trends or utilization issues regarding the timing of claims adjudication. For purposes of this analysis, adjudication is the process by which the outcome of a claim for health care services submitted to a CMO is determined, either systematically or manually. Through the adjudication process, a claim may pay, deny or have an alternative outcome.

The information resulting from the various claims analyses includes the following:

1) ***Summary of Claims Adjudication Statistics*** – The information in this analysis includes the total number of claims adjudicated, the number of claims automatically adjudicated, statistics on the various lengths of time between the time claims are submitted and the time they are adjudicated, and the amount of interest paid by the CMO.

2) ***Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt*** – This analysis displays the top ten reasons claims denied ten or more days after the claim was received by the CMO.

REGULATORY REQUIREMENTS

As described under 42 CFR 447 (b), a Clean claim "means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."

Cahaba Government Benefit Administrators LLC, who is the Medicare Part B administrator in Georgia defines a clean claim as "…claim that does not contain a defect requiring the Medicare contractor to investigate or develop prior to adjudication."

The DCH Model CMO contract has the following definition for clean claims:

"A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: i. A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; ii. A Claim for which Fraud is suspected; and iii. A Claim for which a Third Party Resource should be responsible."

Under the Prompt Pay regulations found in Section 13-11-4 (a) of the Georgia Code, "When a contractor has performed in accordance with the provisions of the contract, the

owner shall pay the contractor within 15 days of receipt by the owner or the owner's representative of any payment request based upon work completed or service provided under the contract".

Because the Georgia Department of Insurance routinely measures Prompt Pay compliance of the CMOs, our analysis does not attempt to duplicate the analysis of the Department of Insurance. Our analysis does not differentiate clean and non-clean claims but rather reports the number of claims adjudicated within 15 days of receipt by the CMO.

In addition to the summary findings below, please also refer to Exhibit 5 for additional information and findings from these analyses. *Note that none of the figures in this analysis incorporate suspended claims since the suspended claims files we received were a snapshot of claims suspended at a point in time.*

FINDINGS

AMGP – CHOA Only – Please Refer to Exhibit 5a
According to the data we received from AMGP, approximately 95 percent of the CHOA hospital claims, excluding suspended claims, were adjudicated within 15 days. Approximately three percent of their claims adjudicated on or after 180 days.

AMGP paid interest of more than $164,000 on CHOA claims, including interest on claims that adjudicated within 15 days. We were not able to confirm whether the interest paid on the claims that were adjudicated within 15 days was related to claims that had previously been adjudicated incorrectly.

We also analyzed the denial reason codes on those CHOA claims that denied 10 or more days after submission. Approximately 45 percent of these denial reasons indicate the claim was a definite duplicate of another claim.

AMGP – Non-CHOA Hospitals – Please Refer to Exhibit 5b
AMGP adjudicated approximately 96 percent of the non-CHOA hospital claims, excluding suspended claims, within 15 days, and 99 percent within 30 days.

AMGP paid interest of more than $70,000 on non-CHOA hospital claims, including interest on claims that adjudicated within 15 days. We were not able to confirm whether the interest paid on the claims that were adjudicated within 15 days was related to claims that had previously been adjudicated incorrectly.

Approximately 22 percent of the non-CHOA hospital claims that denied 10 or more days after submission included denial reason codes indicating the claims were definite duplicates of other claims. Thirteen percent of these claims had no denial reason code within the data provided to us by AMGP.

PSHP – CHOA Only – Please Refer to Exhibit 5c
Approximately 93 percent of CHOA hospital claims were adjudicated by PSHP within 15 days. Three percent of their claims were adjudicated after more than 120 days. These percentages do not include suspended claims. PSHP paid interest of more than $96,000 to CHOA for claims adjudicated in 15 or more days.

Thirty-six percent of the CHOA hospital claims that denied 10 or more days after submission included denial reason codes indicating the claims were duplicates of other claims. Thirteen percent indicate the service was not reimbursable, and an additional eight percent indicate the provider did not bill the service with their national provider identifier (NPI).

PSHP – Non-CHOA Hospitals – Please Refer to Exhibit 5d
Ninety-one percent of the non-CHOA hospital claims submitted to PSHP adjudicated within 15 days. This percentage does not incorporate suspended claims. PSHP paid more than $400,000 in interest for the claims that adjudicated in 15 or more days.

Twenty-eight percent of the non-CHOA hospital claims that denied 10 or more days after submission included denial reason codes indicating the claims were duplicates of other claims. Approximately 10 percent of these denial reasons indicate the provider did not bill the service with their national provider identifier (NPI).

WellCare – CHOA Only – Please Refer to Exhibit 5e
According to the data we received from WellCare, approximately 97 percent of the CHOA hospital claims were adjudicated within 15 days. This percentage does not incorporate suspended claims.

We could not confirm that WellCare paid interest on any CHOA claims based on the data we received. WellCare submitted additional information regarding interest after the review period. This information was not analyzed.

Forty-one percent of the CHOA hospital claims that WellCare denied 10 or more days after submission included denial reason codes indicating the service did not have prior authorization. An additional 31 percent indicate that the service was a duplicate of another.

WellCare – Non-CHOA Hospitals – Please Refer to Exhibit 5f
WellCare adjudicated approximately 99 percent of the non-CHOA hospital claims within 15 days. This percentage does not incorporate suspended claims. According to the data provided by WellCare, we could not confirm that WellCare paid interest on any non-CHOA hospital claims.

Approximately 39 percent of non-CHOA hospital claims that WellCare denied 10 or more days after submission included reason codes stating that the provider did not

receive prior authorization for the service. Twenty percent of the claims denied 10 or more days after submission due to reason codes indicating that the claims were exact duplicates.

ANALYSIS VI: GEORGIA FAMILIES PROGRAM PROVIDER RETENTION

The Department requested that Myers and Stauffer analyze whether hospital providers have terminated their contracts with CMOs or reduced their level of participation. We performed various tests of the claims data and provider enrollment files to evaluate whether any apparent trends existed with the retention of providers participating in the Georgia Families program. Our analyses sought to identify whether hospital providers were reducing or eliminating their claims submissions to the CMOs, either as a participating or a nonparticipating provider, during the period we tested.

Please also refer to Exhibit 6 for additional information regarding provider retention.

FINDINGS

CHOA Facilities

We analyzed 15 months of CHOA claims data from each CMO and nine months of claims data for all other hospitals, in addition to the provider enrollment files of each plan. Based on the enrollment files we received from the CMOs, no CHOA hospital providers appear to have terminated their contracts with the CMOs during the period analyzed.

All other Facilities

AMGP - Non-CHOA Hospitals – Please Refer to Exhibit 6b

Our analysis of AMGP hospital claims data did not reveal any cases were claims submissions dropped to zero following a period of consistent, stable submissions. We did note a large decrease in claims submissions for Doctors Hospital of Augusta and Medical College of GA. However, we cannot ascertain any potential reason(s) for this decrease, since both providers appear to have been enrolled with the CMO during the entire period analyzed. We do note that according to the data from the CMOs there are about 35 claims pending as of the last data provided for Medical College of Georgia. All 35 claims are pending prior authorization.

PSHP - Non-CHOA Hospitals – Please Refer to Exhibit 6d

Our analysis of PSHP claims data did not reveal any cases were claims submissions dropped to zero following a period of consistent, stable submissions. We did note a large decrease in claims submissions for Tift General Medical Center. However, we cannot ascertain any potential reason(s) for this decrease as the provider appears to have been enrolled with the CMO during the entire period analyzed.

WellCare - Non-CHOA Hospitals – Please Refer to Exhibit 6f

During our analysis of hospital claims submissions for non-CHOA providers we noted that Northlake Medical Center's claims submissions dropped to zero following December 2006. We were able to determine that this provider closed on or about December 15, 2006.

In addition, Newnan Hospital's claims submissions decreased significantly in early 2007. According to Newnan's website, the hospital was purchased by Piedmont Healthcare in January 2007. This provider appears under the name Piedmont Newnan Hospital in the PSHP claims data and has claims submissions beginning in March 2007 with PSHP.

We noted no other cases where claims submissions decreased to zero for WellCare hospital providers. A few providers have decreased claims submissions but these providers appear to still be participating with the health plan during the period analyzed.

ANALYSIS VII: HOSPITAL CLAIM DENIALS RELATED TO MEMBER ELIGIBILITY

DCH requested that Myers and Stauffer analyze the denied claims related to member eligibility. We performed several analyses of the data provided by the CMOs in an effort to determine whether the CMO claims presented any apparent trends relating to the timing of their loading or other issues with member eligibility files. In addition, we utilized member lock-in data provided by DCH's claims processing fiscal agent in these analyses.

Please also refer to Exhibit 7 for additional information regarding claim denials related to member eligibility. *Note that none of the figures in this analysis incorporate suspended claims since the suspended claims files we received were a snapshot of claims suspended at a point in time.*

FINDINGS

AMGP – CHOA Only – Please Refer to Exhibit 7a

We identified 513 CHOA hospital claims that were denied by AMGP due to member eligibility issues. Of the 513 denied claims, five were later re-adjudicated and paid.

Next, we attempted to compare the claims denied by the CMO for eligibility issues to the member lock-in file provided by DCH's fiscal agent. This file contains the dates a Medicaid member is "locked-in" to a CMO. Comparing the denied claims to this file may provide additional information in order to determine whether the CMO denied a claim incorrectly for a member that should have been eligible for payment.

Of the more than 500 claims denied, 80 claims or 16 percent of denied claims (less than one percent of all CHOA AMGP claims) were for members that, according to DCH's fiscal agent, were locked-in to AMGP during the time the denied service occurred. These 80 claims represented $99,841 in hospital charges. All five of the claims that originally denied and were later re-adjudicated were for members that, according to DCH's fiscal agent's lock-in file, were locked-in to AMGP and eligible at the date of service.

AMGP – Non-CHOA Hospitals – Please Refer to Exhibit 7b

Our analysis of the claims data provided by AMGP identified 3,325 non-CHOA hospital claims that denied due to member eligibility issues. Of the denied claims, 19 were later re-adjudicated and paid. Of the 19, 18 were for members that, according to DCH's fiscal agent's lock-in file, were locked-in to AMGP and eligible at the date of service.

In addition, of the more than 3,000 claims denied, 129 claims (four percent of denied claims or less than one percent of all paid and denied AMGP non-CHOA claims) were for members that according to DCH's fiscal agent were locked-in to AMGP during the

time the denied service occurred. These 129 claims represented $367,534 in hospital charges.

PSHP – CHOA Only – Please Refer to Exhibit 7c
We analyzed PSHP claims data and identified over 1,500 CHOA claims denied due to member eligibility issues. Forty-seven of the more than 1,500 denied claims were later re-adjudicated and paid.

We compared the CHOA claims denied by PSHP for member eligibility to the member lock-in file provided by DCH's fiscal agent. Of the more than 1,500 claims denied, 189 claims or 12 percent of denied claims (less than one percent of all PSHP paid and denied CHOA claims) were for members that according to DCH's fiscal agent were locked-in to PSHP during the time the denied service occurred. These 189 claims represented $1,820,068 in hospital charges. Of the 47 claims that originally denied and were later re-adjudicated, 44 claims were for members that according to DCH's fiscal agent's lock-in file were locked-in to PSHP and eligible at the date of service.

PSHP – Non-CHOA Hospitals – Please Refer to Exhibit 7d
According to the PSHP claims data, over 7,700 non-CHOA hospital claims denied due to member eligibility issues. Of these denied claims, more than 400 were later re-adjudicated and paid.

We compared the hospital claims denied by PSHP for member eligibility to the member lock-in file provided by DCH's fiscal agent. Of the more than 7,700 claims denied, 1,487 claims or 19 percent of denied claims (less than one percent of all paid and denied PSHP non-CHOA claims) were for members that according to DCH's fiscal agent were locked-in to PSHP during the time the denied service occurred. The 1,487 claims represented $15,060,257 in hospital charges. Of the 412 claims that originally denied and were later re-adjudicated, 401 claims were for members that according to DCH's fiscal agent's lock-in file were locked-in to PSHP and eligible at the date of service.

WellCare – CHOA Only – Please Refer to Exhibit 7e
Our analysis of the CHOA claims data submitted to us by WellCare revealed that twelve CHOA hospital claims (a fraction of a percentage of all WellCare CHOA denied claims) were denied due to reasons indicating the member was not eligible. Of these 12 claims, five were later re-adjudicated and paid by WellCare.

In addition, we compared the CHOA claims denied by WellCare due to member eligibility issues to the member lock-in file provided by DCH's fiscal agent. Of the 12 claims denied, seven claims were for members that according to DCH's fiscal agent were locked-in to WellCare during the time the denied service occurred. Of the five claims that originally denied and were later re-adjudicated four were for members that according to DCH's fiscal agent's lock-in file were locked-in to WellCare and eligible at the date of service.

WellCare – Non-CHOA Hospitals – Please Refer to Exhibit 7f

We analyzed all non-CHOA hospital claims data from WellCare and determined that 292 hospital claims (a fraction of a percentage of all WellCare denied claims) were denied due to reasons indicating the member was not eligible. Of the 292 denied claims, 82 were later re-adjudicated and paid by WellCare.

We then compared the claims denied by WellCare due to member eligibility issues to the member lock-in file provided by DCH's fiscal agent. Of the 292 claims denied, 272 claims or 93 percent were for members that according to DCH's fiscal agent were locked-in to WellCare during the time the denied service occurred. Of the 82 claims that originally denied and were later re-adjudicated 81 were for members that according to DCH's fiscal agent's lock-in file were locked-in to WellCare and eligible at the date of service.

ANALYSIS VIII: ACCURACY OF HOSPITAL PROVIDER RATES

DCH requested that Myers and Stauffer analyze the accuracy with which the three CMOs loaded hospital provider reimbursement rates into their claims payment systems. We performed several analyses of the data provided by the CMOs in an effort to determine whether the CMO information presented any apparent trends or inaccuracies with their loading of provider rates.

In addition to the findings presented below, please also refer to Exhibit 8 for additional information regarding the accuracy of loading hospital provider rates. *Note that none of the figures in this analysis incorporate suspended claims since the suspended claims files we received were a snapshot of claims suspended at a point in time.*

FINDINGS

AMGP – CHOA and All Other Non-CHOA Hospital Providers – Please Refer to Exhibit 8a

Our analysis of AMGP's rate file, claims data, and hospital contracts reveals that 14 outpatient hospital rates from 14 hospitals were loaded into the CMO's claims payment system incorrectly. All 14 of these rates incorrectly loaded in the claims payment system are lower than the rates specified in the contract between AMGP and the providers. Approximately 28,000 distinct claims through August 31, 2007 are potentially impacted by these rates.

In addition, one inpatient hospital contract rate from one hospital appears to have been loaded into the CMO's claims payment system incorrectly at rates lower than those specified in the contract between the CMO and the provider. This rate issue potentially impacts approximately 300 claims.

During the time period covered by this analysis, 83 hospitals were contracted with AMGP.

PSHP – CHOA and All Other Non-CHOA Hospital Providers – Please Refer to Exhibit 8b

We analyzed PSHP's rate file, claims data, and hospital contracts. The analysis appears to indicate that five outpatient hospital rates from five hospitals were loaded into the CMO's claims payment system incorrectly. Two of the rates were loaded into the claims payment system at levels higher than the rates specified in the contract between PSHP and the providers. Three of the rates were lower that the amount specified in the contract. Approximately 11,000 outpatient hospital claims are potentially impacted by these rate issues.

In addition, five inpatient hospital contract rates from five hospitals appear to have been incorrectly loaded into the CMO's claims payment system incorrectly. Three of these loaded rates are higher than those specified in the contract; two were lower than those

specified in the contract. These rate issues potentially impact approximately 1,400 claims.

During the time period covered by the analysis, 102 hospitals were contracted with PSHP.

WellCare – CHOA and All Other Non-CHOA Hospital Providers – Please Refer to Exhibit 8c

Our analysis of WellCare's rate files, claims data, and hospital contracts reveals no apparent differences between the contracted rates and the inpatient and outpatient hospital rates loaded into the system.

During the time period covered by this analysis, 154 hospitals were contracted with WellCare.

ANALYSIS IX: EMERGENCY ROOM VISITS PAID AT TRIAGE RATES

DCH requested that Myers and Stauffer analyze emergency room payments made by the three CMOs. We performed various tests of the claims data in an effort to determine emergency room reimbursement trends for each of the CMOs.

The managed care provisions of the Balanced Budget Act of 1997 (BBA 97) at 42 CFR 438.114 defines an emergency medical condition as a "medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy; (2) Serious impairment to bodily functions; (3) Serious dysfunction of any bodily organ or part.

For reference, a summary of the emergency room reimbursement methodology by CMO is included below.

AMGP

AMGP reimburses emergency room claims based on the CPT code billed (99281-99285) with the revenue code directed in the provider contract and does not use a diagnosis code list to base payment decisions. They also do not use time, day of week, or age of the patient criteria to make payment decisions.

We asked AMGP to describe how they apply the prudent layperson criteria when adjudicating claims and to describe the staff resources and qualifications used in this process. In response to our inquiry, AMGP provided the following response: "Not applicable to [AMGP]".

PSHP

We received the following information from PSHP on 03/28/08 regarding their emergency room claim payment process.

> *"PSHP pays emergency room (ER) claims using two (2) different methods, an automated process and a non-automated process. At the time of contracting with PSHP, each hospital makes an independent decision based on its own preference as to which process it prefers for the adjudication of ER claims.*
>
> *The automated process addresses the concerns of providers who want to be paid sooner and also relieves them from the time and expense involved in gathering and submitting medical records and other supporting documentation. Under the automated process and to facilitate administrative simplicity, PSHP has established specific ICD-9 codes that are automatically approved for payment. The provider manual explains the process for billing under the automated process. Emergency room claims are not denied under the automated*

process. Under this process all claims are paid at the full-negotiated rate for ER services or a lower emergency administrative fee. In addition, the provider has the ability to appeal claims paid at the emergency administrative fee rate.

For non-contracted providers and contracted provider who elect not to participate in the automated process, claims are paid at the full emergency services rate (i.e., network or non-network rate), an emergency administrative fee or denied. Consistent with the automated process, the non-automated process pays claims that have the specified ICD-9 codes in the primary diagnosis field at the applicable emergency services rate. For claims not coded with one of the specified ICD-9 codes, the hospital is sent a request for applicable medical records and supporting documentation. This information enables PSHP to perform a manual, prudent lay person review to determine eligibility for coverage, the applicable payment rate or if the claim should be denied. "

PSHP also confirmed that they are using DCH's version of the diagnosis code list for reimbursement of emergency room claims, however they do not deny an emergency room claim based on the diagnosis code list. There are no CPT codes on this list. PSHP also confirmed that the time of day, day of the week, and/or age of the patient are taken into consideration when making a determination regarding an emergent condition either in the claims adjudication or the appeal process.

We asked PSHP to describe how they apply the prudent layperson criteria when adjudicating claims and also to provide a description of staff resources and qualifications used in this process. Their response is as follows:

"The claim is reviewed by a non-clinical CCM analyst. The CCM analyst reviews the ED record, specifically evaluating the member's presenting symptoms (at the time of triage in the ER) and whether or not they meet the PLP definition of an emergency as defined in the contract agreement between Georgia DCH and PSHP. The CCM analyst works under the supervision of a registered nurse in order to ensure correct interpretation of the medical record and facilitate the decision with respect to the presence or absence of an obvious medical emergency."

WellCare

Based on the information received from WellCare, we do not have sufficient information to provide a detailed description of the emergency room payment policies. Some of the information received from WellCare included calculations of their emergency room claims payment. This information could not be independently confirmed and therefore, was not included in this report.

Regarding the use of a "presumptive emergency or autopayable" list, WellCare stated the following on 3/27/08:

"As independently validated by the FourThought Group, 'Specifically, WellCare does not use a fixed list of diagnosis (DX) codes to determine what is considered an emergent versus non-emergent condition' (FourThought Group, Emergency Room Claims Monitoring, pg 14)."

Additionally, when asked if the presumptive emergency or auto-payable list is identical to the list utilized by DCH for traditional Medicaid or a list of their own development and if the list includes CPT codes, their response was "N/A".

We inquired of WellCare if a presumptive emergency or auto-payable list is not used, what process does WellCare employ to process emergency room claims, and are triage rates or medical records used. WellCare provided the following response:

"*'WellCare has developed an automated 'presumptive' list of DX codes that does not limit what will be considered an emergent condition, but instead, 'presumptively' or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.' (FourThought Group, Emergency Room Claims Monitoring, pg. 12) 'Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program…are not specific enough to warrant an emergency determination in the WellCare system' 'These claims would need to be resubmitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims' (FourThought Group, Emergency Room Claims Monitoring, p. 12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims."*

WellCare was also asked if the time of day, day of the week, or the age of patient information is a factor in determining payment for emergency room claims. WellCare provided the following response:

"'The WellCare System does not currently consider day of the week (weekend vs. weekday, time of day of presentation to the ER, or member age' (FourThought Group, Emergency Room Claims Monitoring, p 13), during the claim adjudication process, unless the medical records are provided with the initial claim submission. These factors are taken into consideration when medical records and documents are submitted during the ER reconsideration and appeals process, but can not be considered as a sole determining factor when assessing the condition."

Lastly, WellCare was asked to describe their process for applying the prudent layperson criteria and the qualifications of personnel involved in this process. WellCare provided the following response:

"'WellCare has developed an automated 'presumptive' list of DX codes that does not limit what will be considered an emergent condition, but instead, 'presumptively' or automatically treats certain claims as an emergency condition. This facilitates automated, systematic payment of a claim at the ER rate.' (FourThought Group, Emergency Room Claims Monitoring, p.12) 'Hospitals billing non-emergent DX codes in the admitting, primary, secondary and tertiary diagnosis fields which may have been considered emergencies under the Medicaid FFS program are not specific enough to warrant an emergency determination in the WellCare system' 'These claims would need to be resubmitted via the reconsideration process, with additional documentation, in order to be further classified as emergency claims.' (FourThought Group, Emergency Room Claims Monitoring, p.12-13). Claims not considered as an emergency condition are adjudicated and paid at the individual contracted rate for non-emergent claims."

Hospital claims submitted to managed care organizations include the emergency levels of screening and treatment. These levels range from CPT code 99281 ("Straightforward medical decision making") to CPT code 99285 ("Medical decision making of high complexity"). These codes reflect not only the complexity of the treatment but also the time and difficulty of making a diagnosis. In an April 2000 letter to State Medicaid Directors, CMS advised that absent provider up-coding, CPT codes 99283 - 99285 "very likely" meet the federal prudent layperson standard of a true "emergency". The Georgia Families Program CMOs pay non-emergency visits to the ER at a contracted triage rate, usually $50, and claims for which the services are determined to be for a true "emergency" at a higher emergency rate as specified by the provider contract.

Based on claims data received from each CMO, our analyses sought to identify the frequency at which hospital emergency room claims are reimbursed at the triage rates when the claims were coded with CPT codes 99281, 99282, 99283, 99284 and 99285.

Please also refer to Exhibit 9 for additional information regarding these analyses. *Note that none of the figures in this analysis incorporate suspended claims since the suspended claims files we received were a snapshot of claims suspended at a point in time.*

FINDINGS

AMGP – CHOA Only – Please Refer to Exhibit 9a

Our analysis of the CHOA emergency room claims paid by AMGP indicates that 100 percent of all claims submitted with CPT codes 99283, 99284 or 99285 were paid at emergency rates. Approximately 11 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal. Please note that AMGP figures exclude hospital claims that did not also have a corresponding ER Physician Claim.

AMGP - CHOA Claims						
Level	Total Claims	No. of Claims Paid at Triage Rate	No. of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate	Number of Claims Originally Paid at Triage and Later Paid as Emergent	Percent of Claims Originally Paid at Triage Later Paid as Emergent
99281	0	0	0	0.00%	0	N/A
99282	160	160	0	100.00%	17	10.63%
99283	180	0	180	0.00%	0	N/A
99284	70	0	70	0.00%	0	N/A
99285	39	0	39	0.00%	0	N/A
Total	**449**	**160**	**289**	**35.63%**	**17**	**10.63%**

AMGP – Non-CHOA Hospitals – Please Refer to Exhibit 9b

Emergency room claims data for AMGP non-CHOA hospital providers indicated that the frequency of triage rate payments for CPT codes 99283, 99284 and 99285 ranged from approximately 11 percent for CPT code 99283 to one percent for CPT code 99285. Approximately 1.5 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal. Please note that AMGP figures exclude hospital claims that did not also have a corresponding ER Physician Claim.

AMGP - Other Hospitals						
Level	Total Claims	No. of Claims Paid at Triage Rate	No. of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate	Number of Claims Originally Paid at Triage and Later Paid as Emergent	Percent of Claims Originally Paid at Triage Later Paid as Emergent
99281	477	127	350	26.62%	1	0.79%
99282	6,628	1,205	5,423	18.18%	41	3.40%
99283	39,972	4,304	35,668	10.77%	48	1.12%
99284	17,003	892	16,111	5.25%	9	1.01%
99285	4,910	49	4,861	1.00%	0	0.00%
Total	**68,990**	**6,577**	**62,413**	**9.53%**	**99**	**1.51%**

PSHP – CHOA Only – Please Refer to Exhibit 9a

The results of our analysis of the CHOA emergency room claims paid by PSHP indicated that the frequency of triage rate payments for CPT codes 99283, 99284 and 99285 ranged from approximately 23 percent for CPT code 99283 to 11 percent for 99285. Approximately 58 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal. Please note that PSHP figures exclude hospital claims that did not also have a corresponding ER Physician Claim.

Peach State - CHOA Claims						
Level	Total Claims	No. of Claims Paid at Triage Rate	No. of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate	Number of Claims Originally Paid at Triage and Later Paid as Emergent	Percent of Claims Originally Paid at Triage Later Paid as Emergent
99281	27	11	16	40.74%	9	81.82%
99282	4,976	1,563	3,413	31.41%	968	61.93%
99283	7,490	1,749	5,741	23.35%	942	53.86%
99284	2,568	437	2,131	17.02%	266	60.87%
99285	2,262	252	2,010	11.14%	159	63.10%
Total	**17,323**	**4,012**	**13,311**	**23.16%**	**2,344**	**58.42%**

PSHP – Non-CHOA Hospitals – Please Refer to Exhibit 9b

Non-CHOA hospital provider data from PSHP indicated that the frequency of triage rate payments for CPT codes 99283, 99284 and 99285 ranged from approximately 12 percent for CPT code 99283 to three percent for CPT code 99285. Approximately 42 percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal. Please note that PSHP figures exclude hospital claims that did not also have a corresponding ER Physician Claim.

Peach State - Other Hospitals						
Level	Total Claims	No. of Claims Paid at Triage Rate	No. of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate	Number of Claims Originally Paid at Triage and Later Paid as Emergent	Percent of Claims Originally Paid at Triage Later Paid as Emergent
99281	15,514	5,990	9,524	38.61%	2,427	40.52%
99282	49,372	14,487	34,885	29.34%	6,198	42.78%
99283	90,899	10,932	79,967	12.03%	4,555	41.67%
99284	29,776	1,898	27,878	6.37%	872	45.94%
99285	8,502	260	8,242	3.06%	132	50.77%
Total	**194,063**	**33,567**	**160,496**	**17.30%**	**14,184**	**42.26%**

WellCare – CHOA Only – Please Refer to Exhibit 9a

WellCare CHOA emergency room claims data shows that a significant number of the claims paid by WellCare with CPT codes 99283 – 99285 were reimbursed at the triage rate. Claims billed with CPT code 99283 were reimbursed the triage rate 76 percent of the time. Claims billed with CPT code 99285 were paid the triage rate in 44 percent of

the cases. Approximately seven percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal. Please note that WellCare figures exclude hospital claims that did not also have a corresponding ER Physician Claim.

WellCare - CHOA Claims						
Level	**Total Claims**	**No. of Claims Paid at Triage Rate**	**No. of Claims Paid at Emergency Rate**	**Percent of Total Claims Paid at Triage Rate**	**Number of Claims Originally Paid at Triage and Later Paid as Emergent**	**Percent of Claims Originally Paid at Triage Later Paid as Emergent**
99281	12	8	4	66.67%	0	0.00%
99282	931	637	294	68.42%	1	0.16%
99283	7,229	5,547	1,682	76.73%	326	5.88%
99284	2,261	1,242	1,019	54.93%	137	11.03%
99285	403	177	226	43.92%	76	42.94%
Total	**10,836**	**7,611**	**3,225**	**70.24%**	**540**	**7.09%**

WellCare – Non-CHOA Hospitals – Please Refer to Exhibit 9b

Based on the claims data from WellCare, non-CHOA hospital providers receive the triage rate on 39 percent of all claims paid for CPT code 99283, 31 percent of claims paid for 99284, and 24 percent of claims paid for CPT code 99285. Approximately one percent of triage claims are later paid at emergency room rates following a provider reconsideration or appeal. Please note that WellCare figures exclude hospital claims that did not also have a corresponding ER Physician Claim.

WellCare - Other Hospitals						
Level	**Total Claims**	**No. of Claims Paid at Triage Rate**	**No. of Claims Paid at Emergency Rate**	**Percent of Total Claims Paid at Triage Rate**	**Number of Claims Originally Paid at Triage and Later Paid as Emergent**	**Percent of Claims Originally Paid at Triage Later Paid as Emergent**
99281	1,904	1,045	859	54.88%	0	0.00%
99282	18,571	9,043	9,528	48.69%	86	0.95%
99283	105,163	41,204	63,959	39.18%	352	0.85%
99284	41,996	12,981	29,015	30.91%	126	0.97%
99285	9,164	2,172	6,992	23.70%	35	1.61%
Total	**176,798**	**66,445**	**110,353**	**37.58%**	**599**	**0.90%**

RECOMMENDATIONS AND HOUSE BILL 1234

FINDING ONE: Contract Loading and Provider Setup Timeliness and Accuracy Issues

We reviewed over 330 contracts between the CMOs and hospital providers. We found that the contractual terms for approximately 42% of these contracts were loaded into the CMO's systems prior to the effective date of the contract. Of the remaining 58% of contracts, the average number of days between the contract effective date and the date it was loaded was approximately 52 days. However, the range was between 1 day and 357 days. There were 26 contracts that required more than 90 days to be loaded. Fifteen of these contracts required more than 120 days to be loaded. This finding is likely a function of the high volume of enrolling providers, coupled with available capacity by the CMOs at the time when the Georgia Families Program was implemented. It is likely that a new provider entering a CMO network today would not require the lengths of time to load the contract as was experienced during implementation.

RECOMMENDATION RELATED TO FINDING ONE

Delays in loading contract terms cause additional strains on both the CMO and hospital. Hospitals must resubmit claims, manage denials, and commit resources to resolving problems. We, therefore, recommend that DCH consider changes to the CMO contract to require a maximum number of days available to load contract terms, as well as additional procedures to confirm the accuracy of provider setups.

OPTIONS RELATED TO RECOMMENDATION ONE

1) DCH may wish to consider requiring the CMOs to load provider contracts within 30 days of the effective date of the contract, unless otherwise authorized by DCH.

2) During implementation periods, DCH may deem it appropriate to extend the contract loading requirement to 60 days.

3) Upon loading of contracts, DCH may wish to consider requiring CMOs to generate a report of the effective and end dates, facility characteristics (e.g., physical address, payment address, etc), provider-based entities as applicable, effected practice and service groups (e.g., anesthesia groups, emergency

physician groups) billing under the provider identification number, and all provider rates. This report should be submitted to the provider. The provider should carefully review and upon concurrence, sign the document and return a copy to the CMO. The CMOs and providers should maintain a copy of the document.

4) DCH may wish to consider requiring CMOs to submit copies or summaries of contracts, amendments, notices of cancellation, or other necessary provider information sufficient to allow DCH to monitor and evaluate the adequacy of the provider networks, identify trends in the time necessary to load and setup provider terms in the CMO claims processing system.

5) DCH may wish to consider monitoring compliance of the requirement to load provider contracts within 30 days or other applicable period determined by DCH. Section 4.10 of the contract between DCH and the CMO includes provisions that "Upon request, the [CMO] shall provide DCH with free copies of all executed Provider Contracts."

FINDING TWO: Credentialing Timeliness Issues

For hospitals that were not credentialed prior to their effective date as a network provider, the average number of days required to complete credentialing was 85 days. For 13 providers, it appears as if credentialing required more than 100 days. Similar to the contract loading finding listed above, the length of time required to complete credentialing for some hospitals was likely a function of the available capacity at the implementation of the Georgia Families Program. It is likely that a new provider entering a CMO network today would not experience this length of time to become credentialed, as was experienced during the Georgia Family program implementation.

RECOMMENDATION RELATED TO FINDING TWO

Section 120-2-83-.05(c) of the Department of Insurance regulations require that "Within ninety (90) days of receipt of all necessary information as required by the managed care entity and provided with the nomination form in accordance with Rule 12-2-83.04(a)(1), the managed care entity shall provide notice in writing, to the provider and the enrollee, of the credentialing decision."

We recommend that DCH consider additional requirements for the timeliness of credentialing, perhaps by type of provider.

OPTIONS RELATED TO RECOMMENDATION TWO

1) Given the limited nature of credentialing activities necessary for hospital providers, DCH may wish to consider a requirement that CMOs credential hospital providers within 30 days of application.

2) During periods of CMO startup with the Georgia Family program, DCH could extend the above requirement to the full 90 days permitted by DOI regulation. The National Committee for Quality Assurance (NCQA) permits 180 days for credentialing; however, as stated above it may be appropriate for DCH to impose more stringent requirements than NCQA, particularly for hospital providers.

FINDING THREE: High Claim Denial Rate Related to Prior Authorization Issues

Prior authorization issues account for over 16% of the inpatient and outpatient hospital claims that were denied for payment for the period of the review (June 1, 2006 through August 31, 2007 for CHOA and December 1, 2006 through August 31, 2007 for non-CHOA facilities). Hospital providers reported to us a number of issues with prior authorization including:

- claims impacted by the application of the "72-hour rule" (i.e., when the readmission claim is merged with the original claim, one PA record is also deleted);
- issues related to not understanding the services that require PA;
- issues related to add-on procedures performed during the service (e.g., surgery);
- issues related to data entry of authorizations; and
- issues related to authorizing a specific procedure rather than a family of procedures.

RECOMMENDATION RELATED TO FINDING THREE

Based on the high volume of claim denials for prior authorization issues, we recommend that DCH consider changes to the prior authorization policies and procedures.

OPTIONS RELATED TO RECOMMENDATION THREE

1) Providers and provider associations should work closely with the CMOs on follow-up training workshops, including procedures to track prior authorization requests and responses, better understand CMO prior authorization policies and policy changes, and the differences between CMO prior authorization requirements and traditional Medicaid prior authorization requirements.

2) DCH may wish to consider requiring CMOs to collaboratively develop and utilize a standard prior authorization form.

3) DCH may wish to consider requiring CMOs to provide electronic confirmation to the providers that include all relevant information regarding the authorization request.

4) DCH may wish to consider requiring CMOs to develop automated processes to properly merge and update authorization records when the 72-hour rule is applied.

5) DCH may wish to consider requiring CMOs to update, publish, and maintain a comprehensive list of services that require prior authorization. Updates made to

the lists should be communicated to the provider community and DCH within a specified time period determined by DCH.

6) DCH may wish to consider requiring CMOs to permit payment of medically necessary add-on or additional procedures completed during medical procedures. Providers should be required to notify the CMOs when an additional procedure is completed so that the CMOs can complete a pro-forma change to the authorization request. The CMOs should utilize post payment review to confirm the medical necessity of questionable procedures.

7) DCH may wish to consider requiring CMOs to authorize a family or range of procedure codes rather than a specific code or procedure. This process would improve claims processing efficiency, as the claim billed would more likely be approved based on the criteria in the authorization and less likely to suspend for claims examiner intervention. The decision to authorize a family of procedures or a specific procedure may be specific to the category of service requested.

8) DCH may wish to consider requiring CMOs to evaluate and/or modify prior authorization requirements for categories of service that exceed a pre-determined threshold level of approvals and report specific findings to DCH.

9) DCH may wish to consider requiring CMOs to accept prior authorizations from other plans when members change health plans, based on parameters established by DCH medical staff.

FINDING FOUR: High Claim Denial Rate Related to Claim Coding Policies, Coding Inconsistencies, and Benefit Limits

During our review of denied hospital claims, we noted that approximately 25% of denied hospital claims were related to coding policies, coding inconsistencies, and benefit limits. We reviewed a sample of these claims and in some cases found that the hospital coded the claim in conformance with standard coding requirements.

RECOMMENDATION RELATED TO FINDING FOUR

While it is important to note that based on HIPAA transaction requirements, the use of standard coding principles when coding claims is not always congruent with requirements for reimbursement. CMOs should continue to be permitted to develop specific reimbursement requirements using standard coding. However, providers must have access to this information and understand these requirements.

The DCH model contract states at Sections 4.10.1.5.12 and 4.10.1.5.17 that the contracts between the CMOs and providers must, "Specify Covered Services and populations" and must "specify acceptable billing and coding requirements", respectively. Furthermore, Section 4.16.1.13 requires the CMOs to "make available to network Providers Claims coding and processing guidelines for the applicable Provider type". While perhaps inefficient to include this information within the provider contract, this information should be readily accessible and well understood by both CMOs and hospital providers.

OPTIONS RELATED TO RECOMMENDATION FOUR

1) DCH may wish to consider requiring the CMOs to update, publish, and maintain lists of covered services, services that require prior authorization, services included in global fee periods, specific benefit limitations, age/sex restrictions, and revenue code/procedure code combinations.

2) DCH may wish to consider requiring CMOs to provide periodic training and information seminars for its contracted providers.

3) Providers and provider associations should arrange for training of their staff and association members with CMOs regarding CMO coding policies. Such training should emphasize the differences between CMO coding policies and traditional Medicaid claim coding requirements.

4) CMOs and provider associations may wish to consider developing a mechanism whereby individual providers can communicate lessons learned and issue resolution mechanisms with other providers that may be experiencing similar questions or problems. This option requires that providers and provider

associations share helpful information while maintaining confidentiality, specifically as it pertains to CMO proprietary information.

5) CMOs, providers, and provider associations may wish to establish monthly or quarterly meetings between hospital providers and CMOs to discuss questions, concerns, and issues related to claim coding policies and procedures.

FINDING FIVE: Large Suspended Claims Volume that May Result From CMO's Definitions of Clean Claims

As described under 42 CFR 447.45 (b), a clean claim "means one that can be processed without obtaining additional information from the provider of the service or from a third party. It includes a claim with errors originating in a State's claims system. It does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity."

The Medicare Part B administrator in Georgia (Cahaba Government Benefits Administrators LLC) defines a clean claim as "…claim that does not contain a defect requiring the Medicare contractor to investigate or develop prior to adjudication."

The DCH Model CMO contract has the following definition for clean claims:

"A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines and which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: i. A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; ii. A Claim for which Fraud is suspected; and iii. A Claim for which a Third Party Resource should be responsible."

According to the Prompt Pay regulations found in Georgia Code Section 13-11-4 (a), "When a contractor has performed in accordance with the provisions of the contract, the owner shall pay the contractor within 15 days of receipt by the owner or the owner's representative of any payment request based upon work completed or service provided under the contract".

Our analysis of CMO claims data revealed a large number of suspended claims for two CMOs. One of the two CMOs appears to have paid no interest on any claims during the period we analyzed. This CMO submitted additional information after the review period and therefore, this information was not analyzed.

RECOMMENDATION RELATED TO FINDING FIVE

In order to ensure compliance with prompt pay requirements, we recommend that DCH consider additional CMO monitoring and/or reporting requirements.

OPTIONS RELATED TO RECOMMENDATION FIVE

1) DCH may wish to consider requiring CMOs to identify the specific criteria they use to determine whether a claim meets the definition of a "clean claim". The criteria should include the specific fields and edits/audits in the adjudication process.

2) DCH may wish to consider requiring the CMOs to utilize a “clean claim” flag (i.e., to indicate which claims are “clean”) and the date that the claim was determined “clean” for adjudication purposes. The CMOs could then report, on a monthly or quarterly basis, the number of claims originally submitted as clean, the number of claims requiring additional information, and other information as necessary. Such reporting would provide DCH with the ability to more effectively monitor CMO claim payment performance.

3) If DCH chooses to implement the above options, the information could be used by DCH and the CMOs to identify providers that habitually provide incorrect or incomplete claims to the payor, which would enable the CMO to target appropriate education to the specific provider issues.

FINDING SIX: Timely Filing Denials and Confusion

Section 4.16.1.12 of the DCH contract permits CMOs authority to "deny a claim for failure to file timely if a Provider does not submit Claims to them within one hundred and twenty (120) Calendar Days of the date of service but must deny any Claim not initially submitted to the Contractor by the one hundred and eighty-first (181st) Calendar Day from the date of service, unless the Contractor or its vendors created the error."

Hospital providers described to us several issues related to timely filing of claims, including differences in timely filing requirements between the Medicaid fee-for-service and the CMO/provider contracts, CMOs using admission date as the "date of service" when determining timely filing, and retro-active denials that cannot be appealed due to timely filing requirements.

RECOMMENDATION RELATED TO FINDING SIX

Based on these issues, we recommend that DCH consider changes to the timely filing requirements in the CMO model contract.

OPTIONS RELATED TO RECOMMENDATION SIX

1. DCH may wish to consider requiring CMOs to use the same timely filing standard as traditional fee-for-service Medicaid. House Bill 1234, signed by Governor Perdue on May 13, 2008, contains this provision as a requirement.

2. DCH may wish to consider requiring CMOs to use the discharge date as the "date of service" when applying the timely filing criteria to inpatient hospital claims. All CMOs have recently reported that they have either modified their systems to use discharge date or have implemented work-around solutions to address claims that deny based on admission date.

3. During periods of implementation, DCH may wish to consider requiring CMOs to suspend timely filing edits for claims for issues other than provider related causes. The CMOs should work with DCH to establish the parameters of the suspension.

FINDING SEVEN: Apparently Improper Claim Denials for Members That Appear to Have Been Eligible for CMO Coverage

Approximately 5% of hospital denied claims are for reasons related to member eligibility. We identified situations where a claim denied due to member eligibility, yet the lock-in file from the Medicaid fiscal agent indicated the member was locked-in to the CMO on the date the service was provided.

It appears that a number of these situations are likely the result of timing issues regarding exchange of information between the Medicaid fiscal agent and the CMOs. Many hospital providers reported to us that they often receive claim denials for member eligibility despite having received verification of the member's eligibility at the time of service.

Section 33-21A-9 of HB 1234 addresses this concern by requiring that "If provider submits claims within 72 hours of verification of eligibility, the responsible health organization will reimburse the provider in an amount equal to what provider would have received if patient was enrolled as shown in the verification process. After payment to the provider, the responsible health organization may pursue payment from the responsible party, but may not recover the payment from the provider. If the provider verifies eligibility and submits claims, but then finds out another payor is responsible, the provider may submit a claim to the responsible payor and receive payment for medically necessary services without application of a timely filing penalty, failure to get prior authorization, or for the provider not being in a participating network. Reimbursement for this service should be at least FFS rate."

RECOMMENDATION RELATED TO FINDING SEVEN

In order to ensure that Medicaid and PeachCare for Kids™ members continue to receive appropriate care and that providers and CMOs are appropriately reimbursed for covering and providing service to members, DCH may wish to make changes to the process whereby CMOs are notified of the members locked-in to coverage with their plan.

OPTIONS RELATED TO RECOMMENDATION SEVEN

1. DCH may wish to review the current data file exchange process between the CMOs and the Medicaid fiscal agent and consider increasing the frequency of member eligibility updates. We understand that this process currently occurs every two weeks. We recommend that DCH consider a daily electronic file transfer.

2. DCH may wish to require CMOs to identify discrepancies between enrollment and the fiscal agent lock-in file. Once the lock-in file has been sent to the CMOs, the CMOs should complete an electronic reconciliation between the lock-in file and their enrollment files. Differences should be reported back to the fiscal agent contractor and DCH for additional research and resolution of the discrepancy.

FINDING EIGHT: Several Claims Payment Components and CMO Performance Indicators May Require Additional Monitoring for Contract Compliance

The results of these analyses and our experience with other Medicaid programs suggests that ongoing and continuous monitoring of various claims payment components and CMO performance indicators would be useful tools to ensure that the CMOs comply with the terms of their contracts with DCH and continue to meet their obligations to members and providers.

RECOMMENDATION RELATED TO FINDING EIGHT

We recommend additional monitoring of the CMOs in three specific areas.

OPTIONS RELATED TO RECOMMENDATION EIGHT

1. DCH may wish to monitor several financial indicators, including:

    a. Medical loss ratio
    b. Administrative loss ratio
    c. Current ratio (current assets / current liabilities - an indication of a plan's solvency, or its ability to meet its short-term obligations)
    d. Days cash on hand (indicates the number of days the plan could cover operating expenses with its current available cash)
    e. Ratio of cash to claims payable (indicates the effectiveness of a plan's ability to pay off claims payable with available cash and short term investments)
    f. Days in claims payable (the number of days of claims a plan owes its claimants,
    g. Medicaid profit margin

2. DCH may wish to monitor several claim indicators, including:

    a. Suspended claims volume
    b. Denial claims volume
    c. Interest payments
    d. Claims paid at emergency and triage rates
    e. Number of emergency room related reconsideration/appeal requests and overturn statistics
    f. Adjudication statistics
    g. Prior authorization approval/denial rates

3. DCH may wish to monitor several provider network and access Indicators, including:

a. Participating providers by specialty
b. Voluntary provider terminations
c. Contract loading timeliness
d. Credentialing timeliness
e. Member plan changes

FINDING NINE: Emergency Room Coverage and Reimbursement Issues

Section 4.6.1 of the contract between DCH and the CMOs provides a basis of coverage and reimbursement requirements for the CMOs. The provisions of the contract closely correlate to the Federal Regulations defining emergency medical conditions at 42 CFR 438.114 and 42 CFR 489.24. Our analyses indicate that the CMOs use different methodologies, policies and procedures of both applying the definition of emergent medical conditions and reimbursement of emergent and non-emergent conditions. This variation has caused confusion on the part of hospitals and inconsistent treatment of hospitals across the state.

Hospital claims submitted to the CMOs include the emergency levels of screening and treatment. These levels range from CPT code 99281 ("Straightforward medical decision making") to CPT code 99285 ("Medical decision making of high complexity"). These codes reflect not only the complexity of the treatment but also the time required and difficulty of making a diagnosis. In an April 2000 letter to State Medicaid Directors, CMS advised that absent provider up-coding, CPT codes 99283 - 99285 "very likely" meet the federal prudent layperson standard of a true "emergency".

The Georgia Families Program CMOs pay non-emergency visits to the ER at a contracted triage rate, usually $50. The CMOs generally reimburse claims for which the services are determined to be for a true "emergency" at a higher emergency rate as specified by the provider contract.

Two of the three CMOs pay a significant number of claims with CPT codes 99283 – 99285 at the triage rate. In one case, the data suggest that a high percentage of these claims are eventually paid at the emergency room rate but only after provider reconsideration. Two of the three CMOs do not consider the time of day, day of the week or the age of patient when determining payment for emergency room claims.

Section 33-21A-4 of HB 1234 includes the following provisions regarding the processing of claims for emergency health care services:

> In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:
> (1) The age of the patient;
> (2) The time and day of the week the patient presented for services;
> (3) The severity and nature of the presenting symptoms;
> (4) The patient's initial and final diagnosis; and
> (5) Any other criteria prescribed by the Department of Community Health, including criteria specific to patients under 18 years of age.

Furthermore, HB 1234 gives DCH additional authority to…." develop and publish a list of additional standards to be used by…" the CMOs "…to maximize the identification and accurate payment…" of ER claims.

Based on feedback from Georgia hospital providers, it appears that certain hospitals did not always perform an adequate or thorough review of the contracts with the CMOs prior to signing the contracts. Furthermore, some hospitals indicated to us that, in certain cases they relied on information, terms, discussion, and agreements with CMOs representatives that were not specified in the executed contracts.

RECOMMENDATION RELATED TO FINDING NINE

We recommend that DCH consider significant changes to the policies and procedures used by the CMOs to identify, process, and pay emergency room claims. Additional information and recommendations regarding emergency room utilization and reimbursement will follow under separate cover.

OPTIONS RELATED TO RECOMMENDATION NINE

1. DCH may wish to consider requiring CMOs to use a standardized approach for reimbursing emergency department claims. The standardized approach could be based on either CPT code or diagnosis code. Utilizing a standardized approach would minimize confusion with hospitals and variation among plans, and would reduce the cost of both hospitals and CMOs in managing and reviewing a significant volume of medical records, reconsiderations, and appeals.

   Should DCH consider a "CPT" list approach, all emergency department claims would be treated as true emergent situations that meet the prudent layperson standard. Hospital providers would code the appropriate procedure code considering all conditions and factors consistent with standard coding principles, HB 1234, and their contract with the CMOs. Medical charts would not be required to be submitted to or reviewed by the CMOs. CMOs could utilize post payment review to confirm correct coding by hospitals.

   Should DCH consider a "diagnosis" list approach, all claims using a diagnosis on the list would represent a presumed emergent condition. DCH would provide a minimum list of presumed conditions. CMOs could add additional diagnoses to the minimum list. Claims with a diagnosis on the presumed list would automatically be paid as a true emergency. For any diagnosis not on the presumed list, the hospital would be required to submit medical charts at the time of the claim submission. The CMOs would be required to complete a prudent layperson review of the claim, considering all necessary factors and conditions in compliance with HB 1234 and the DCH contract, and determine reimbursement either at the true emergency rate or the triage rate. The following two recommendations apply only if DCH considers a diagnosis code approach:

a. DCH may wish to consider requiring CMOs to publish and make available to hospitals the list of "presumed" emergent medical conditions.

b. DCH may wish to consider requiring CMOs to use the definition of emergency health care services described in the DCH model contract, the prudent layperson provisions of Federal law, and the provisions of HB 1234 in the emergency room claim adjudication process, as well as in contracts with their network providers. The same definition should be used by each CMO and CMO/provider contract.

2. DCH may wish to consider requiring CMOs to evaluate emergency room reimbursement and coverage policies and modify their criteria based on reconsideration and appeal overturn rates.

3. Hospitals have ultimate responsibility for the contracts they execute and should exercise greater due diligence before signing off on contracts with CMOs. Hospital providers should review contracts with managed care entities and ensure that all provisions are clear and unambiguous within the contract itself, and any verbal assurances by a representative of a health plan are detailed in writing within the contract.

4. DCH may wish to consider updating and completing an annual evaluation and assessment of the list of presumed emergency diagnoses codes used in the fee-for-service program.

5. We would encourage the Georgia hospital associations to develop tools that can be used by its membership, such as a guide to ensure that certain contract terms and specificity are included in the contract between CMO and provider. These tools or guides should not include or address CMO proprietary information.

FINDING TEN: Claims Reprocessing for Known Claims Issues

Hospital providers reported to us that CMOs do not generally reprocess claims after making provider rate changes, fee changes as a result of Medicaid fee changes, or other claims processing system changes. We were able to confirm with one CMO that the CMO will not automatically reprocess claims. This CMO indicated that changes are only applied to provider's claims when the provider contacts the CMO regarding the particular issues.

RECOMMENDATION RELATED TO FINDING TEN

As it pertains to system correction and fee related updates, we recommend that DCH consider requirements that CMOs reprocess claims for known claims issues.

OPTIONS RELATED TO RECOMMENDATION TEN

DCH may wish to consider a requirement that the CMOs identify, report, prioritize, and reprocess all provider claims impacted by system changes, fee schedule changes, or other claims system changes.

House Bill 1234

House Bill 1234, termed the "CMO Reform Bill", was the General Assembly's response to provider issues presented to Georgia legislators. House Bill 1234 was passed by the 2007-2008 Georgia General Assembly on April 4, 2008, and was signed into law by Governor Perdue on May 13, 2008.

Many of the provisions of House Bill 1234 appear to address the observations, findings, and recommendations included in this report. In addition, the Department of Community Health has informed us that they have incorporated the provisions of House Bill 1234 and many of our recommendations into the most recent CMO contract.

The full version of House Bill 1234 is available on the internet at: www.legis.state.ga.us .

A summary of the relevant sections of the bill follows:

Chapter 21A 33-21A-4 – Emergency Room Services

- CMOs cannot deny or inappropriately reduce payment of ER services.
- CMOs cannot make payment contingent on notification.
- CMOs "…shall consider, at the time that the claim is submitted" at least:
    - Age of patient
    - Time and day of week
    - Severity and nature of presenting symptoms
    - Patient's initial and final diagnosis
    - Any other criteria "…prescribed…" by DCH
    - CMO will configure or program system to consider at least the criteria for ER services.
- DCH "…may develop and publish a list of additional standards to be used by…" the CMOs "…to maximize the identification and accurate payment…" of ER claims.
- Non contracted provider will receive the FFS Medicaid rate for ER and post-stabilization services.

Chapter 21A 33-21A-7 – Provider Complaints and Appeals

- CMO will allow providers to consolidate their complaints or appeals of multiple claims that involve similar payment or coverage issues, regardless of the number.
- CMO will allow a provider that has exhausted the CMO's appeal process to use the administrative review process or binding arbitration.
    - Arbitrator has 90 days from when selected to render a decision.
    - The costs for arbitration will be shared equally between the CMO and provider.
- Claims that have been denied or underpaid, then overturned and paid by CMO will be subject to "…interest of 20 percent per annum, calculated from 15 days after the date the claim was submitted." Interest is to be paid when claim is paid and accurately identified on the remittance advice. The CMO is not responsible for interest if the claim contains inaccuracy or omissions.

- CMO will "…maintain a website that allows providers to submit, process, edit, rebill, and adjudicate claims electronically."
- CMO will remit payment electronically if the provider is capable, and submit the remittance advice within one business day of payment.
- CMO will have a searchable list of contracted providers on their website. The list must be updated at least monthly.
- CMO will use same timeframes for submission, processing, payment, denial, adjudication, and appeal as fee-for-service Medicaid.
- CMO will not make the provider participate in other plans or products as a condition of contracting. Violation of $1000.00 per occurrence with the penalty collected by DCH. The CMO cannot reduce funding available to members as a result of penalty payment.
- Provider cannot require CMO to contract or not contract with another provider as a condition of contracting. Violation of $1000.00 per occurrence with the penalty collected by DCH. The Provider cannot terminate a contract due to a penalty.

Chapter 21A 33-21A-9 – Member Eligibility

- If provider submits claims within 72 hours of verification of eligibility, the responsible health organization will reimburse the provider in an amount equal to what provider would have received if patient was enrolled as shown in the verification process. After payment to the provider, the responsible health organization may pursue payment from the responsible party, but may not recover the payment from the provider. If the provider verifies eligibility and submits claims, but then finds out another payor is responsible, the provider may submit a claim to the responsible payor and receive payment for medically necessary services without application of a timely filing penalty, failure to get prior authorization, or for the provider not being in a participating network. Reimbursement for this service should be at least FFS rate.

Chapter 21A 33-21A-10 – CMO Contracts

- On and after effective date, DCH will include this provision in new or renewal contracts with CMOs.
- On and after effective date, CMO will include provisions in new or renewal contracts with providers, which follow these provisions.

EXHIBITS

Georgia Department of Community Health
Georgia Families
Exhibit 1a - AMERIGROUP - CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Children's Healthcare of Atlanta (CHOA) at Egleston	7/20/2006	6/1/2006	7/27/2006	6/1/2006	8/2/2006	49
Children's Healthcare of Atlanta at Scottish Rite	7/20/2006	6/1/2006	7/21/2006	6/1/2006	7/21/2006	49

Dates represent the actual dates provided by the CMOs. See report for comments regarding accuracy of dates being reports.

% of providers with contract entered into system prior to effective date of participating status	0.00%
Average number of days after effective date of participating status to date provider contract was entered:	49

Georgia Department of Community Health
Georgia Families
Exhibit 1b - AMERIGROUP - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Redmond Regional Medical Ctr	8/24/2007	9/1/2006	12/8/2006	12/1/2006	12/9/2006	357
Emory Johns Creek Hospital	9/4/2007	1/18/2007	6/27/2007	2/23/2007	9/5/2007	229
Hamilton Medical Ctr	3/26/2007	12/1/2006	12/15/2006	12/1/2006	12/20/2006	115
Satilla Regional Med Center	12/20/2006	9/1/2006	12/14/2006	11/18/2006	12/20/2006	110
Murray Medical Center	3/20/2007	12/1/2006	12/29/2006	12/1/2006	1/6/2007	109
Candler Hospital	12/18/2006	9/1/2006	12/29/2006	12/1/2006	12/30/2006	108
St Joseph's Hospital	12/18/2006	9/1/2006	1/11/2007	12/1/2006	1/13/2007	108
Athens Regional Medical Ctr	2/14/2007	11/7/2006	12/12/2006	12/1/2006	12/16/2006	99
Polk Medical Center	12/4/2006	9/1/2006	12/8/2006	9/17/2006	12/9/2006	94
Cartersville Medical Center	11/20/2006	9/1/2006	12/8/2006	11/21/2006	12/9/2006	80
Doctors Hospital of Augusta	11/20/2006	9/1/2006	12/8/2006	12/1/2006	12/9/2006	80
Emory Eastside Medical Center	11/20/2006	9/1/2006	12/8/2006	12/1/2006	12/9/2006	80
Union General Hospital	11/28/2006	9/9/2006	12/16/2006	12/1/2006	12/20/2006	80
Chestatee Regional Hospital	11/7/2006	9/1/2006	12/7/2006	12/1/2006	12/9/2006	67
Chatuge Regional Hospital	11/1/2006	9/1/2006	1/10/2007	12/1/2006	1/13/2007	61
Higgins General Hospital	7/31/2006	6/1/2006	12/16/2006	12/1/2006	12/20/2006	60
Jefferson Hospital	7/28/2006	6/1/2006	12/14/2006	10/14/2006	12/16/2006	57
Habersham County Medical Ctr	8/16/2006	6/21/2006	12/20/2006	12/1/2006	12/23/2006	56
Cobb Memorial Hospital	10/24/2006	9/1/2006	12/12/2006	11/12/2006	12/13/2006	53
Emanuel Medical Ctr	10/24/2006	9/1/2006	12/13/2006	12/1/2006	12/16/2006	53
Hart County Hospital	10/24/2006	9/1/2006	12/13/2006	12/1/2006	12/16/2006	53
Hutcheson Medical Ctr	10/24/2006	9/1/2006	12/7/2006	10/9/2006	12/9/2006	53
Minnie G. Boswell Memorial Hospital	10/24/2006	9/1/2006	12/7/2006	12/1/2006	12/9/2006	53
St Mary's Hospital	10/24/2006	9/1/2006	12/8/2006	12/1/2006	12/9/2006	53
McDuffie County Hospital	1/22/2007	12/1/2006	2/9/2007	12/1/2006	2/10/2007	52
Wellstar Kennestone Hospital	7/21/2006	6/1/2006	12/8/2006	12/1/2006	12/9/2006	50
Wellstar Windy Hill Hospital	7/21/2006	6/1/2006	12/12/2006	12/5/2006	12/16/2006	50
Gwinnett Hospital Systems	7/20/2006	6/1/2006	12/8/2006	12/1/2006	12/9/2006	49
Joan Glancy Memorial Hospital	7/20/2006	6/1/2006	NULL	NULL	NULL	49
Newton Medical Ctr	7/20/2006	6/1/2006	12/8/2006	12/2/2006	12/9/2006	49
St Joseph's Hospital of Atlanta	7/20/2006	6/1/2006	12/21/2006	12/6/2006	1/6/2007	49
Tanner Medical Center Carrollton	7/20/2006	6/1/2006	12/16/2006	12/1/2006	12/20/2006	49
Tanner Medical Center - Villa Rica	7/20/2006	6/1/2006	12/16/2006	12/1/2006	12/20/2006	49
Wellstar Cobb Hospital	7/20/2006	6/1/2006	12/8/2006	11/23/2006	12/9/2006	49
Wellstar Douglas Hospital	7/20/2006	6/1/2006	12/7/2006	12/1/2006	12/9/2006	49

Georgia Department of Community Health
Georgia Families
Exhibit 1b - AMERIGROUP - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
WellStar Paulding Hospital	7/20/2006	6/1/2006	12/8/2006	12/1/2006	12/9/2006	49
Piedmont Fayette Hospital	5/19/2006	4/1/2006	12/8/2006	12/1/2006	12/13/2006	48
Piedmont Hospital	5/19/2006	4/1/2006	12/8/2006	12/1/2006	12/16/2006	48
Piedmont Mountainside Hospital	5/19/2006	4/1/2006	12/8/2006	12/1/2006	12/9/2006	48
Jenkins County Hospital	10/17/2006	9/1/2006	1/12/2007	12/1/2006	1/13/2007	46
Meadows Regional Medical Ctr	10/17/2006	9/1/2006	12/9/2006	12/1/2006	12/13/2006	46
Morgan Memorial Hospital	10/17/2006	9/1/2006	12/29/2006	12/1/2006	1/6/2007	46
Candler County Hospital	10/16/2006	9/1/2006	12/9/2006	12/1/2006	12/13/2006	45
Anchor Hospital	10/12/2006	9/1/2006	12/21/2006	12/7/2006	12/30/2006	41
Barrow Regional Medical Ctr	10/12/2006	9/1/2006	12/6/2006	12/1/2006	12/9/2006	41
Burke Medical Center	10/12/2006	9/1/2006	12/8/2006	12/1/2006	12/9/2006	41
Effingham Hospital	10/12/2006	9/1/2006	12/26/2006	12/1/2006	1/20/2007	41
Putnam General Hospital	10/12/2006	9/1/2006	12/7/2006	8/1/2006	12/9/2006	41
Wayne Memorial Hospital	10/12/2006	9/1/2006	12/8/2006	12/1/2006	12/13/2006	41
Charlton Memorial Hospital	10/11/2006	9/1/2006	12/12/2006	12/3/2006	12/13/2006	40
Grady Memorial Hospital	5/11/2006	4/1/2006	12/8/2006	8/26/2006	12/9/2006	40
Hughes Spalding Children's Hospital	7/11/2006	6/1/2006	12/8/2006	10/19/2006	12/13/2006	40
Screven County Hospital	10/11/2006	9/1/2006	12/20/2006	12/1/2006	12/23/2006	40
Walton Regional Medical Ctr	10/11/2006	9/1/2006	12/6/2006	12/1/2006	12/9/2006	40
Southern Regional Medical Ctr	7/3/2006	6/1/2006	12/7/2006	12/1/2006	12/13/2006	32
Washington County Regional Medical Ctr	5/2/2007	4/1/2007	12/15/2006	12/1/2006	12/20/2006	31
Emory Adventist Hospital	4/27/2006	4/1/2006	12/9/2006	12/1/2006	12/13/2006	26
Wesley Woods Center of Emory University	4/27/2006	4/1/2006	5/3/2007	4/3/2007	5/5/2007	26
Emory Crawford Long Hospital	4/25/2006	4/1/2006	12/12/2006	12/1/2006	12/13/2006	24
Emory University Hospital	4/25/2006	4/1/2006	12/13/2006	12/1/2006	12/16/2006	24
Northside Hospital	4/25/2006	4/1/2006	12/8/2006	12/1/2006	12/9/2006	24
Northside Hospital-Cherokee	4/25/2006	4/1/2006	12/8/2006	12/1/2006	12/13/2006	24
Northside Hospital-Forsyth	4/25/2006	4/1/2006	12/8/2006	12/1/2006	12/9/2006	24
North Georgia Medical Ctr	10/2/2006	9/9/2006	12/6/2006	12/1/2006	12/9/2006	23
Piedmont Newnan Hospital	10/9/2006	9/18/2006	12/27/2006	12/1/2006	1/6/2007	21
Evans Memorial Hospital	10/2/2006	9/15/2006	12/16/2006	12/1/2006	12/20/2006	17
Northeast Georgia Medical Center	9/18/2006	9/1/2006	12/9/2006	12/1/2006	12/13/2006	17
Northeast Georgia Medical Ctr-Lanier Park	9/18/2006	9/1/2006	NULL	NULL	2/14/2007	17
Tattnall Community Hospital	9/18/2006	9/1/2006	12/29/2006	12/1/2006	1/3/2007	17
BJC Medical Center	9/22/2006	9/6/2006	12/8/2006	12/1/2006	12/13/2006	16

Georgia Department of Community Health
Georgia Families
Exhibit 1b - AMERIGROUP - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
Legacy Medical Center of Atlanta	11/14/2006	11/3/2006	1/22/2007	12/7/2006	1/27/2007	11
Rockdale Medical Center	6/12/2006	6/1/2006	12/7/2006	12/1/2006	12/9/2006	11
Fannin Regional Hospital	9/11/2006	9/1/2006	12/7/2006	12/1/2006	12/9/2006	10
Henry Medical Center	4/10/2006	4/1/2006	12/16/2006	12/1/2006	12/20/2006	9
Liberty Regional Medical Ctr	9/22/2006	9/14/2006	12/13/2006	12/1/2006	12/16/2006	8
Stephens County Hospital	8/9/2006	8/1/2006	12/16/2006	12/1/2006	12/20/2006	8
Appling Healthcare System	10/2/2006	9/25/2006	12/7/2006	12/1/2006	12/9/2006	7
Shepherd Ctr	6/8/2006	6/1/2006	1/17/2007	12/19/2006	1/20/2007	7
Jasper Memorial Hospital	6/7/2006	6/1/2006	12/9/2006	12/1/2006	12/16/2006	6
Jeff Davis Hospital	10/2/2006	9/27/2006	12/6/2006	12/1/2006	12/9/2006	5
Medical College of GA	9/6/2006	9/1/2006	12/13/2006	12/1/2006	12/16/2006	5
Mountain Lakes Medical Ctr	11/14/2006	11/10/2006	12/30/2006	12/1/2006	1/3/2007	4
Elbert Memorial Hospital	6/3/2006	6/1/2006	12/11/2006	12/1/2006	12/13/2006	2
East Georgia Regional Medical Ctr	2/7/2007	2/6/2007	12/27/2006	12/1/2006	12/30/2006	1
Southeast Georgia Health System - Brunswick Campus	12/20/2006	12/19/2006	12/19/2006	12/1/2006	12/23/2006	1
Memorial Health University Medical Ctr	8/31/2006	9/1/2006	12/8/2006	12/1/2006	12/9/2006	0
Southeast Georgia Health System - Camden Campus	12/20/2006	12/20/2006	12/19/2006	12/1/2006	12/23/2006	0
University Hospital	8/31/2006	9/1/2006	12/16/2006	9/28/2006	12/20/2006	0
Wills Memorial Hospital	12/11/2006	12/11/2006	12/9/2006	12/1/2006	12/16/2006	0

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Dates represent the actual dates provided by the CMOs. See report for comments regarding accuracy of dates being reports.

% of providers with contract entered into system prior to effective date of participating status 4.49%
Average number of days after effective date of participating status to date provider contract was entered: 48

Georgia Department of Community Health
Georgia Families
Exhibit 1c - Peach State Health Plan - CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
CHILDRENS HLTH CARE OF ATL EGLESTON	4/26/2006	6/1/2006	6/27/2006	6/1/2006	7/2/2006	0
SCOTTISH RITE CHILDRENS MED CTR	6/1/2006	6/1/2006	6/26/2006	6/1/2006	7/2/2006	0

Dates represent the actual dates provided by the CMOs. See report for comments regarding accuracy of dates being reports.

% of providers with contract entered into system prior to effective date of participating status 100.00%
Average number of days after effective date of participating status to date provider contract was entered: 0

Georgia Department of Community Health
Georgia Families
Exhibit 1d - Peach State Health Plan - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
BERRIEN COUNTY HOSPITAL	NULL	9/1/2006	12/9/2006	12/1/2006	12/15/2006	NULL
CALHOUN MEMORIAL HOSPITAL	NULL	9/1/2006	12/12/2006	11/1/2006	12/13/2006	NULL
CARTERSVILLE MEDICAL CENTER	NULL	6/1/2006	12/6/2006	12/1/2006	12/13/2006	NULL
COLQUITT REGIONAL HOSPITAL	NULL	9/1/2006	12/7/2006	12/1/2006	12/8/2006	NULL
DECATUR HOSPITAL	NULL	6/1/2006	1/9/2007	12/1/2006	1/10/2007	NULL
DEKALB MEDICAL CENTER	NULL	6/1/2006	12/7/2006	12/1/2006	12/8/2006	NULL
DEKALB MEDICAL CENTER AT HILLANDALE	NULL	6/1/2006	12/7/2006	9/26/2006	12/8/2006	NULL
DORMINY MEDICAL CENTER	NULL	6/1/2006	12/9/2006	12/1/2006	12/15/2006	NULL
EMORY ADVENTIST HOSP	NULL	6/1/2006	12/8/2006	12/1/2006	12/13/2006	NULL
EMORY CRAWFORD LONG HOSPITAL	NULL	6/1/2006	12/8/2006	9/11/2006	12/15/2006	NULL
EMORY EASTSIDE MEDICAL CENTER	NULL	6/1/2006	12/6/2006	12/1/2006	12/13/2006	NULL
ERLANGER MEDICAL CENTER	NULL	7/1/2007	8/6/2007	6/4/2007	8/10/2007	NULL
GRADY HEALTH SYSTEM	NULL	6/1/2006	12/8/2006	10/16/2006	12/11/2006	NULL
HABERSHAM COUNTY MEDICAL CENTER	NULL	6/1/2006	4/11/2007	3/16/2007	4/13/2007	NULL
HENRY MEDICAL CENTER	NULL	6/1/2006	12/13/2006	6/19/2006	12/20/2006	NULL
HUGHES SPALDING CHILDRENS HOSP	NULL	6/1/2006	12/8/2006	9/25/2006	12/11/2006	NULL
LOUIS SMITH MEMORIAL HOSPITAL	NULL	9/1/2006	12/12/2006	10/10/2006	12/13/2006	NULL
MEDICAL COLLEGE OF GEORGIA HOSPITAL	NULL	3/1/2007	12/12/2006	12/1/2006	12/18/2006	NULL
MEMORIAL HOSPITAL AND MANOR	NULL	9/1/2006	12/9/2006	12/1/2006	12/13/2006	NULL
MITCHELL COUNTY HOSPITAL	NULL	9/1/2006	12/12/2006	10/5/2006	12/15/2006	NULL
OCONEE REGIONAL MEDICAL CENTER	NULL	6/1/2006	12/7/2006	12/1/2006	12/13/2006	NULL
PIEDMONT HOSPITAL	NULL	6/1/2006	12/8/2006	8/14/2006	12/15/2006	NULL
PIEDMONT NEWNAN HOSPITAL	NULL	3/1/2007	6/15/2007	9/12/2006	6/19/2007	NULL
SHEPHERD CENTER	NULL	6/1/2006	12/18/2006	12/1/2006	12/20/2006	NULL
SOUTH GEORGIA MEDICAL CENTER	NULL	9/1/2006	12/12/2006	11/2/2006	12/15/2006	NULL
SPECIALTY LABO	NULL	5/1/2007	NULL	NULL	NULL	NULL
ST MARYS HOSPITAL	NULL	3/1/2007	12/7/2006	12/1/2006	12/11/2006	NULL
STEWART WEBSTER HOSPITAL	NULL	6/1/2006	12/29/2006	12/1/2006	1/3/2007	NULL
SYLVAN GROVE HOSPTIAL TENET	NULL	6/1/2006	12/8/2006	12/1/2006	12/15/2006	NULL
TANNER MEDICAL CENTER- VILLA RICA	NULL	6/1/2006	12/12/2006	12/1/2006	12/15/2006	NULL
TANNER MEDICAL CENTER-CARROLLTON	NULL	7/1/2006	12/6/2006	12/1/2006	12/13/2006	NULL
TCT CHILDRENS HOSPITAL	NULL	7/1/2007	12/12/2006	8/17/2006	12/15/2006	NULL
UPSON REGIONAL MEDICAL CENTER	NULL	6/1/2006	12/7/2006	11/25/2006	12/8/2006	NULL
WARM SPRINGS MEDICAL CENTER	NULL	6/1/2006	12/18/2006	12/1/2006	12/26/2006	NULL
WESLEY WOOD CTR OF EMORY UNIVERSITY	NULL	6/1/2006	1/12/2007	1/5/2007	1/26/2007	NULL

Georgia Department of Community Health
Georgia Families
Exhibit 1d - Peach State Health Plan - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
WEST GEORGIA MEDICAL CTR	NULL	10/1/2006	1/3/2007	10/24/2006	2/9/2007	NULL
TIFT GENERAL MEDICAL CENTER	7/27/2007	9/1/2006	12/12/2006	7/3/2006	12/15/2006	329
TAYLOR TELFAIR REGIONAL HOSPITAL	2/27/2007	6/1/2006	12/13/2006	12/1/2006	12/20/2006	271
EFFINGHAM HOSP & CARE CTR	10/19/2006	6/1/2006	7/16/2007	6/27/2007	7/24/2007	140
GORDON HOSPITAL	10/2/2006	6/1/2006	12/18/2006	12/5/2006	12/20/2006	123
POLK MEDICAL CENTER	9/25/2006	6/1/2006	12/20/2006	12/4/2006	12/26/2006	116
REDMOND REGIONAL MEDICAL CENTER	9/25/2006	6/1/2006	12/12/2006	12/1/2006	12/13/2006	116
WASHINGTON CNTY REGIONAL MED CENTER	9/19/2006	6/1/2006	12/14/2006	12/1/2006	12/20/2006	110
LIBERTY REGIONAL MEDICAL CENTER	9/6/2006	6/1/2006	12/13/2006	12/1/2006	12/15/2006	97
PHOEBE PUTNEY MEMORIAL HOSPITAL	8/28/2006	6/1/2006	12/8/2006	10/9/2006	12/11/2006	88
PHOEBE PUTNEY MEMORIAL HOSPITAL	8/28/2006	6/1/2006	1/18/2007	10/18/2006	1/26/2007	88
NORTHSIDE HOSPITAL	8/15/2006	6/1/2006	12/7/2006	12/1/2006	12/15/2006	75
NORTHSIDE HOSPITAL-FORSYTH	8/15/2006	6/1/2006	12/7/2006	12/1/2006	12/15/2006	75
GEORGE H LANIER MEMORIAL HOSPITAL	8/14/2006	6/1/2006	12/8/2006	12/1/2006	12/20/2006	74
SMITH NORTHVIEW HOSPITAL	8/14/2006	6/1/2006	12/9/2006	12/1/2006	12/15/2006	74
ST JOSEPH HOSPITAL OF ATLANTA	8/14/2006	6/1/2006	12/14/2006	12/1/2006	12/20/2006	74
SCREVEN COUNTY HOSPITAL	8/8/2006	6/1/2006	2/5/2007	12/26/2006	2/9/2007	68
COLISEUM MEDICAL CENTER	7/31/2006	6/1/2006	12/6/2006	10/2/2006	12/13/2006	60
FAIRVIEW PARK HOSPITAL	7/31/2006	6/1/2006	12/6/2006	7/7/2006	12/11/2006	60
PALMYRA MEDICAL CENTER	7/31/2006	6/1/2006	12/6/2006	12/1/2006	12/13/2006	60
BACON COUNTY HOSPITAL	7/18/2006	6/1/2006	1/17/2007	12/22/2006	1/19/2007	47
CLINCH MEMORIAL HOSPITAL	10/2/2006	9/1/2006	12/13/2006	11/17/2006	12/15/2006	31
NORTHSIDE HOSPITAL- CHEROKEE	6/20/2006	6/1/2006	12/7/2006	9/30/2006	12/15/2006	19
BROOKS COUNTY HOSPITAL	9/19/2006	9/1/2006	12/18/2006	10/4/2006	12/20/2006	18
SATILLA REGIONAL MEDICAL CTR	9/15/2006	9/1/2006	12/15/2006	12/1/2006	12/26/2006	14
SOUTHERN REGIONAL MEDICAL CENTER	6/14/2006	6/1/2006	12/7/2006	12/1/2006	12/8/2006	13
DONALSONVILLE HOSPITAL	9/13/2006	9/1/2006	1/3/2007	10/7/2006	1/5/2007	12
JASPER MEMORIAL HOSPITAL AND REHAB	6/10/2006	6/1/2006	12/8/2006	12/1/2006	12/15/2006	9
WHEELER COUNTY HOSPITAL	6/7/2006	6/1/2006	12/7/2006	12/2/2006	12/8/2006	6
BARROW REGIONAL MEDICAL CENTER	6/5/2006	6/1/2006	12/6/2006	12/1/2006	12/13/2006	4
MILLER COUNTY HOSPITAL	6/5/2006	6/1/2006	12/6/2006	12/1/2006	12/11/2006	4
PIEDMONT FAYETTE HOSPITAL	6/5/2006	6/1/2006	12/8/2006	12/1/2006	12/15/2006	4
PIEDMONT MOUNTAINSIDE HOSPITAL	6/5/2006	6/1/2006	12/9/2006	12/2/2006	12/15/2006	4
ARCHBOLD MEDICAL CENTER	7/18/2006	9/1/2006	12/8/2006	9/4/2006	12/13/2006	0
ATLANTA MEDICAL CENTER-TENET	3/1/2006	6/1/2006	12/7/2006	8/10/2006	12/13/2006	0

Georgia Department of Community Health
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Exhibit 1d - Peach State Health Plan - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
BLECKLEY MEMORIAL HOSPITAL	2/8/2006	6/1/2006	12/9/2006	12/1/2006	12/15/2006	0
CANDLER COUNTY HOSPITAL	2/8/2006	6/1/2006	1/9/2007	12/30/2006	1/19/2007	0
CHARLTON MEMORIAL HOSPITAL	4/26/2006	6/1/2006	3/20/2007	2/25/2007	3/23/2007	0
CHESTATEE REGIONAL HOSPITAL	9/19/2006	10/10/2006	1/30/2007	12/7/2006	4/17/2007	0
CHILDRENS HLTH CARE OF ATL EGLESTON	4/26/2006	6/1/2006	NULL	NULL	NULL	0
COFFEE REGIONAL MEDICAL CTR	11/1/2005	6/1/2006	12/11/2006	12/1/2006	12/28/2006	0
COFFEE REGIONAL MEDICAL CTR	11/1/2005	6/1/2006	1/16/2007	12/10/2006	2/20/2007	0
COLISEUM NORTHSIDE HOSPITAL	3/29/2006	6/1/2006	12/6/2006	8/22/2006	12/13/2006	0
CRISP REGIONAL HOSP	11/9/2005	6/1/2006	12/16/2006	8/13/2006	12/20/2006	0
DOCTORS HOSPITAL OF COLUMBUS	4/19/2006	6/1/2006	12/6/2006	12/1/2006	12/13/2006	0
DODGE COUNTY HOSP	2/8/2006	6/1/2006	12/13/2006	10/28/2006	12/20/2006	0
DODGE COUNTY HOSP	2/8/2006	6/1/2006	NULL	NULL	NULL	0
EARLY MEMORIAL HOSPITAL	7/18/2006	9/1/2006	12/18/2006	12/1/2006	12/20/2006	0
ELBERT MEMORIAL HOSPITAL	9/19/2006	10/1/2007	NULL	NULL	NULL	0
EMANUEL COUNTY HOSPITAL	8/3/2006	2/1/2007	12/19/2006	12/2/2006	12/20/2006	0
EMORY UNIVERSITY HOSPITAL	4/25/2006	6/1/2006	12/13/2006	12/1/2006	12/20/2006	0
EVANS MEMORIAL HOSP INC	1/16/2006	6/1/2006	12/19/2006	12/1/2006	12/26/2006	0
FLINT RIVER COMMUNITY HOSP	4/21/2006	6/1/2006	12/6/2006	12/1/2006	12/15/2006	0
FLOYD MEDICAL CENTER	3/1/2006	3/1/2007	5/14/2007	12/22/2006	5/23/2007	0
GRADY GENERAL HOSPITAL	7/18/2006	9/1/2006	12/9/2006	12/1/2006	12/15/2006	0
GWINNETT MEDICAL CENTER	4/28/2006	6/1/2006	12/8/2006	8/21/2006	12/11/2006	0
HIGGINS GENERAL HOSPITAL	4/26/2006	6/1/2006	12/12/2006	12/1/2006	12/15/2006	0
HOUSTON MEDICAL CENTER	5/22/2006	6/1/2006	12/8/2006	12/1/2006	12/15/2006	0
HUGHSTON SPORTS MEDICINE HOSPITAL	3/29/2006	6/1/2006	12/12/2006	12/5/2006	12/13/2006	0
IRWIN COUNTY HOSPITAL	2/28/2006	6/1/2006	12/8/2006	12/1/2006	12/15/2006	0
JEFF DAVIS HOSPITAL	3/6/2006	6/1/2006	12/12/2006	12/7/2006	12/15/2006	0
JOAN GLANCY MEMORIAL HOSPITAL	4/28/2006	6/1/2006	12/8/2006	12/1/2006	12/15/2006	0
MEDICAL CENTER INC	3/1/2006	6/1/2006	12/6/2006	12/1/2006	12/8/2006	0
MEDICAL CENTER OF CENTRAL GA	3/1/2006	6/1/2006	12/6/2006	12/1/2006	12/8/2006	0
MEMORIAL HEALTH UNIVERSITY MED CTR	12/21/2006	3/1/2007	12/18/2006	12/1/2006	12/20/2006	0
MEMORIAL HOSPITAL OF ADEL	8/1/2006	9/1/2006	12/6/2006	12/1/2006	12/15/2006	0
MONROE COUNTY HOSPITAL	2/10/2006	6/1/2006	12/8/2006	12/2/2006	12/15/2006	0
NEWTON MEDICAL CENTER	4/11/2006	6/1/2006	12/8/2006	12/1/2006	12/13/2006	0
NORTH FULTON REGION HOSP TENET	3/29/2006	6/1/2006	12/8/2006	12/1/2006	12/15/2006	0
NORTH GEORGIA MEDICAL CENTER	9/19/2006	10/1/2006	NULL	NULL	NULL	0

Georgia Department of Community Health
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Exhibit 1d - Peach State Health Plan - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
NORTH GEORGIA MEDICAL CENTER	9/19/2006	10/10/2006	12/30/2006	8/14/2006	1/3/2007	0
PEACH REGIONAL MEDICAL CENTER	3/1/2006	6/1/2006	12/7/2006	12/1/2006	12/15/2006	0
PEACH REGIONAL MEDICAL CENTER	3/1/2006	6/1/2006	NULL	NULL	NULL	0
PERRY HOSPITAL	5/22/2006	6/1/2006	12/12/2006	12/1/2006	12/15/2006	0
PHOEBE WORTH HOSPITAL	8/28/2006	9/1/2006	12/13/2006	12/1/2006	12/15/2006	0
PUTNAM GENERAL HOSPITAL	2/8/2006	6/1/2006	12/30/2006	12/2/2006	1/3/2007	0
ROCKDALE MEDICAL CENTER	1/6/2006	6/1/2006	12/7/2006	7/10/2006	12/8/2006	0
ROOSEVELT WARM SPRINGS INST FOR REHA	4/27/2006	6/1/2006	12/15/2006	8/23/2006	12/20/2006	0
SOUTH FULTON MEDICAL CTR TENET	3/29/2006	6/1/2006	12/6/2006	12/1/2006	12/8/2006	0
SOUTHEAST ALABAMA MED CTR	10/2/2006	2/1/2007	12/13/2006	12/4/2006	12/15/2006	0
SOUTHWEST GEORGIA REGIONAL	8/28/2006	9/1/2006	12/9/2006	12/1/2006	12/15/2006	0
SPALDING REGIONAL HOSPITAL	3/29/2006	6/1/2006	12/6/2006	11/28/2006	12/8/2006	0
ST FRANCIS HOSPITAL	12/8/2006	1/1/2007	12/7/2006	6/15/2006	12/8/2006	0
SUMTER REGIONAL HOSPITAL	8/31/2006	9/1/2006	12/8/2006	12/1/2006	12/13/2006	0
TAYLOR REGIONAL HOSPITAL	10/14/2005	6/1/2006	12/9/2006	12/1/2006	12/11/2006	0
WALTON MEDICAL CENTER	9/7/2005	6/1/2006	12/6/2006	12/1/2006	12/15/2006	0
WAYNE MEMORIAL HOSPITAL	2/15/2006	6/1/2006	2/15/2007	1/6/2007	2/20/2007	0

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Dates represent the actual dates provided by the CMOs. See report for comments regarding accuracy of dates being reports.
PeachState did not provide the date provider was entered as an in-network provider for all providers. Percentages and averages only reflect those providers with date entered.

% of providers with contract entered into system prior to effective date of participating status 62.79%
Average number of days after effective date of participating status to date provider contract was entered: 71

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Exhibit 1e - WellCare - CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
CHOA AT EGLESTON	4/11/2007	1/15/2007	6/17/2006	6/1/2006	6/23/2006	86
CHOA AT SCOTTISH RITE	4/11/2007	1/15/2007	6/17/2006	6/1/2006	6/23/2006	86

Dates represent the actual dates provided by the CMOs. See report for comments regarding accuracy of dates being reports.

% of providers with contract entered into system prior to effective date of participating status	0.00%
Average number of days after effective date of participating status to date provider contract was entered:	86

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Exhibit 1f - WellCare - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
DOUGLAS HOSPITAL	9/7/2007	1/1/2007	12/6/2006	6/23/2006	8/1/2006	249
KENNESTONE HOSPITAL	9/7/2007	1/1/2007	12/8/2006	6/3/2006	6/22/2006	249
PAULDING HOSPITAL	9/7/2007	1/1/2007	12/7/2006	6/2/2006	6/20/2006	249
WELLSTAR COBB HOSPITAL	9/7/2007	1/1/2007	12/8/2006	6/4/2006	6/23/2006	249
WINDY HILL HOSPITAL	9/7/2007	1/1/2007	12/21/2006	8/25/2006	9/12/2006	249
AUGUSTA HOSPITAL	3/5/2007	10/1/2006	3/5/2007	9/22/2006	3/13/2007	155
MEMORIAL HOSPITAL	1/31/2007	9/1/2006	12/14/2006	12/4/2006	12/27/2006	152
MEMORIAL NORTH PARK HOSPITAL	1/31/2007	9/1/2006	2/23/2007	2/4/2007	3/2/2007	152
WEST GEORGIA MEDICAL CENTER	2/12/2007	10/1/2006	12/14/2006	6/1/2006	7/25/2006	134
SOUTHERN REGIONAL MED CTR	9/21/2006	7/1/2006	12/7/2006	6/1/2006	6/20/2006	82
SE GEORGIA HEALTH SYS-BRUNSWICK CAMPUS	11/15/2006	9/1/2006	12/8/2006	9/1/2006	10/10/2006	75
SCREVEN COUNTY HOSPITAL	11/14/2006	9/1/2006	12/20/2006	9/13/2006	10/26/2006	74
GRADY MEMORIAL HOSPITAL	9/6/2007	7/1/2007	12/8/2006	6/1/2006	6/27/2006	67
MORGAN MEMORIAL HOSPITAL	11/1/2006	9/1/2006	12/12/2006	9/20/2006	11/17/2006	61
ST MARYS HEALTH CARE SYSTEM	10/30/2006	9/1/2006	12/7/2006	6/13/2006	8/1/2006	59
NEWTON MEDICAL CENTER	2/28/2007	1/2/2007	12/6/2006	6/1/2006	6/23/2006	57
PERRY HOSPITAL	8/25/2007	7/1/2007	12/7/2006	6/4/2006	7/11/2006	55
MEDICAL CENTER OF CENTRAL GEORGIA	8/17/2007	7/1/2007	12/5/2006	6/1/2006	6/20/2006	47
NORTH GEORGIA MEDICAL CENTER	8/17/2007	7/1/2007	12/6/2006	6/17/2006	8/15/2006	47
PARKRIDGE EAST HOSPITAL	10/9/2006	9/1/2006	12/6/2006	9/1/2006	10/12/2006	38
PARKRIDGE VALLEY HOSPITAL	10/9/2006	9/1/2006	7/16/2007	3/18/2007	7/24/2007	38
MILLER COUNTY HOSPITAL	1/6/2007	12/1/2006	12/5/2006	10/4/2006	10/24/2006	36
SATILLA REGIONAL MEDICAL CENTER	10/6/2006	9/1/2006	12/15/2006	8/9/2006	10/6/2006	35
JASPER MEMORIAL HOSPITAL	1/4/2007	12/1/2006	12/9/2006	6/21/2006	9/5/2006	34
JEFFERSON HOSPITAL	1/4/2007	12/1/2006	1/12/2007	9/3/2006	10/20/2006	34
HUGHES SPALDING CHILDRENS HOSPITAL	7/5/2006	6/2/2006	12/8/2006	6/1/2006	7/11/2006	33
HUTCHESON MED CENTER	1/2/2007	12/1/2006	12/7/2006	9/2/2006	10/3/2006	32
LANIER HEALTH SERVICES	10/3/2006	9/1/2006	12/9/2006	6/10/2006	10/27/2006	32
BJC MEDICAL CENTER	9/29/2006	9/1/2006	12/8/2006	9/1/2006	12/8/2006	28
MEADOWS REGIONAL MEDICAL CENTER	9/28/2006	9/1/2006	12/8/2006	6/1/2006	8/22/2006	27
CANDLER HOSPITAL	9/27/2006	9/1/2006	12/7/2006	9/2/2006	10/12/2006	26
TIFT REGIONAL MEDICAL CENTER	9/27/2006	9/1/2006	12/9/2006	8/27/2006	9/19/2006	26
DOCTORS HOSPITAL	6/26/2006	6/1/2006	4/25/2006	6/3/2006	8/17/2006	25
PALMYRA MEDICAL CENTERS	6/26/2006	6/1/2006	12/6/2006	10/9/2006	10/24/2006	25

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Exhibit 1f - WellCare - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
POLK MEDICAL CENTER	6/26/2006	6/1/2006	12/6/2006	7/30/2006	11/3/2006	25
REDMOND REGIONAL MEDICAL CTR	6/26/2006	6/1/2006	12/6/2006	6/1/2006	7/21/2006	25
DORMINY MEDICAL CENTER	9/25/2006	9/1/2006	12/9/2006	9/3/2006	10/19/2006	24
WASHINGTON COUNTY REGIONAL MEDICAL CTR	9/22/2006	9/1/2006	12/8/2006	9/3/2006	11/7/2006	21
WILLS MEMORIAL HOSPITAL	9/21/2006	9/1/2006	12/9/2006	9/5/2006	10/27/2006	20
HAMILTON MEDICAL CENTER	9/20/2006	9/1/2006	12/7/2006	9/1/2006	10/10/2006	19
MEMORIAL HOSPITAL OF ADEL	9/19/2006	9/1/2006	12/11/2006	10/4/2006	10/30/2006	18
SOUTH GEORGIA MEDICAL CENTER	9/19/2006	9/1/2006	12/11/2006	7/26/2006	10/30/2006	18
CLINCH MEMORIAL HOSPITAL	9/18/2006	9/1/2006	12/26/2006	12/5/2006	1/5/2007	17
ELBERT MEMORIAL HOSPITAL	9/18/2006	9/1/2006	12/8/2006	9/12/2006	10/5/2006	17
GWINNETT MEDICAL CENTER	11/16/2006	11/1/2006	12/8/2006	6/1/2006	6/22/2006	15
BROOKS COUNTY HOSPITAL	11/15/2006	11/1/2006	12/19/2006	10/3/2006	12/19/2006	14
CHESTATEE REGIONAL HOSPITAL	9/15/2006	9/1/2006	12/7/2006	7/7/2006	10/20/2006	14
GRADY GENERAL HOSPITAL	11/15/2006	11/1/2006	12/8/2006	9/13/2006	10/12/2006	14
MITCHELL COUNTY HOSPITAL	11/15/2006	11/1/2006	12/15/2006	9/15/2006	11/7/2006	14
EARLY MEMORIAL HOSPITAL	11/14/2006	11/1/2006	12/13/2006	8/25/2006	11/17/2006	13
JOHN D ARCHBOLD MEMORIAL HOSP	11/14/2006	11/1/2006	12/12/2006	6/5/2006	11/9/2006	13
CHATUGE REGIONAL HOSPITAL INC	9/13/2006	9/1/2006	12/19/2006	9/3/2006	11/3/2006	12
HABERSHAM COUNTY MEDICAL CENTER	9/13/2006	9/1/2006	12/8/2006	9/1/2006	10/3/2006	12
OCONEE REG MEDICAL CENTER	7/13/2007	7/1/2007	12/8/2006	6/1/2006	6/22/2006	12
APPLING HEALTHCARE SYSTEM	9/12/2006	9/1/2006	12/7/2006	6/3/2006	9/19/2006	11
COBB MEMORIAL HOSPITAL	9/12/2006	9/1/2006	12/9/2006	9/4/2006	10/13/2006	11
HART COUNTY HOSPITAL	9/12/2006	9/1/2006	12/9/2006	7/30/2006	9/21/2006	11
MEMORIAL HEALTH UNIVERSITY MED CTR	9/12/2006	9/1/2006	2/23/2006	9/1/2006	10/13/2006	11
SUMTER REGIONAL HOSPITAL	9/11/2006	9/1/2006	12/8/2006	6/1/2006	6/23/2006	10
ATHENS REGIONAL MEDICAL CENTER	9/8/2006	9/1/2006	12/7/2006	6/9/2006	9/14/2006	7
FANNIN REGIONAL HOSPITAL	9/8/2006	9/1/2006	12/7/2006	6/10/2006	8/29/2006	7
STEPHENS COUNTY HOSPITAL	9/7/2006	9/1/2006	12/11/2006	6/6/2006	10/6/2006	6
MEDICAL COLLEGE OF GEORGIA	10/6/2007	10/1/2007	12/6/2006	6/10/2006	7/5/2006	5
NORTHEAST GEORGIA MED CTR-LANIER PARK	9/5/2006	9/1/2006	1/29/2007	9/2/2006	10/6/2006	4
WALTON REGIONAL MEDICAL CTR	6/5/2006	6/1/2006	12/6/2006	6/2/2006	7/14/2006	4
HOUSTON MEDICAL CENTER	8/4/2007	8/1/2007	12/7/2006	6/1/2006	6/23/2006	3
MEMORIAL HOSPITAL AND MANOR	10/4/2007	10/1/2007	12/15/2006	10/9/2006	11/16/2006	3
EMANUEL MEDICAL CENTER	5/2/2007	5/1/2007	12/13/2006	6/22/2006	10/3/2006	1

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Exhibit 1f - WellCare - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
FLOYD MEDICAL CENTER	5/9/2007	5/8/2007	12/7/2006	6/2/2006	7/21/2006	1
JENKINS COUNTY HOSPITAL	5/2/2007	5/1/2007	12/13/2006	6/12/2006	11/9/2006	1
MCDUFFIE REGIONAL MEDICAL CENTER	5/2/2007	5/1/2007	12/8/2006	9/13/2006	10/27/2006	1
NORTHEAST GEORGIA MEDICAL CENTER	9/2/2006	9/1/2006	12/8/2006	6/8/2006	7/21/2006	1
UNIVERSITY HOSPITAL	5/2/2007	5/1/2007	6/20/2006	9/1/2006	11/3/2006	1
ANGEL MEDICAL CENTER	2/8/2007	3/1/2007	3/6/2007	12/1/2006	3/13/2007	0
ATLANTA MEDICAL CENTER	1/26/2006	6/1/2006	12/7/2006	6/3/2006	6/23/2006	0
BACON COUNTY HOSPITAL	3/14/2006	9/1/2006	12/11/2006	8/28/2006	9/19/2006	0
BARROW REGIONAL MEDICAL CTR	4/20/2006	6/1/2006	12/6/2006	6/21/2006	7/14/2006	0
BERRIEN COUNTY HOSPITAL	8/16/2006	9/1/2006	1/18/2007	10/9/2006	1/23/2007	0
BLECKLEY MEMORIAL HOSPITAL	4/20/2006	6/1/2006	12/9/2006	6/10/2006	8/15/2006	0
BLEDSOE HOSPITAL	6/13/2007	7/1/2007	NULL	NULL	NULL	0
BURKE MEDICAL CENTER	3/16/2007	4/1/2007	12/8/2006	9/1/2006	9/19/2006	0
CALHOUN MEMORIAL HOSPTIAL	2/14/2007	4/1/2007	1/12/2007	10/2/2006	1/23/2007	0
CANDLER COUNTY HOSPITAL	3/13/2006	9/1/2006	12/11/2006	8/10/2006	10/30/2006	0
CARTERSVILLE MEDICAL CENTER	2/1/2006	6/1/2006	12/6/2006	6/1/2006	8/8/2006	0
CHARLTON MEMORIAL HOSPITAL	8/15/2006	9/1/2006	12/12/2006	9/6/2006	11/21/2006	0
COFFEE REGIONAL MEDICAL CENTER	2/14/2006	6/1/2006	12/14/2006	7/15/2006	8/15/2006	0
COLISEUM MEDICAL CENTERS	2/7/2006	6/1/2006	12/11/2006	6/1/2006	8/3/2006	0
COLISEUM NORTHSIDE HOSPITAL	5/25/2006	6/1/2006	12/6/2006	6/5/2006	8/10/2006	0
COLQUITT REGIONAL MEDICAL CTR	8/16/2006	9/1/2006	12/7/2006	9/4/2006	9/26/2006	0
COPPER BASIN MEDICAL CENTER	1/16/2007	2/1/2007	12/11/2006	12/1/2006	12/28/2006	0
CRISP REGIONAL HOSPITAL	2/8/2006	6/1/2006	12/13/2006	6/1/2006	8/29/2006	0
DOCTORS HOSPITAL	5/24/2006	6/1/2006	12/6/2006	6/2/2006	8/8/2006	0
DODGE COUNTY HOSPITAL	3/13/2006	9/1/2006	12/13/2006	6/4/2006	7/6/2006	0
DONALSONVILLE HOSPITAL	8/16/2006	9/1/2006	1/3/2007	9/6/2006	11/29/2006	0
EAST GEORGIA REGIONAL MEDICAL CTR	12/20/2006	1/1/2007	12/14/2006	6/30/2006	9/5/2006	0
EFFINGHAM HOSPITAL	3/9/2006	9/1/2006	12/15/2006	7/23/2006	12/7/2006	0
EMORY CRAWFORD LONG HOSPITAL	9/1/2006	9/1/2006	12/12/2006	6/1/2006	7/5/2006	0
EMORY EASTSIDE MEDICAL CTR	5/31/2006	6/1/2006	12/6/2006	6/4/2006	8/3/2006	0
EMORY UNIVERSITY HOSPITAL - MAIN	5/23/2006	6/1/2006	12/12/2006	6/5/2006	7/11/2006	0
EMORY-ADVENTIST HOSPITAL	5/16/2006	6/1/2006	12/8/2006	6/1/2006	7/21/2006	0
ERLANGER BARONESS HOSPITAL	6/20/2007	7/1/2007	3/29/2007	1/15/2007	4/2/2007	0
ERLANGER EAST HOSPITAL	6/13/2007	7/1/2007	12/11/2006	9/16/2006	12/27/2006	0

Georgia Department of Community Health
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Exhibit 1f - WellCare - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
ERLANGER NORTH HOSPITAL	7/11/2007	8/1/2007	7/24/2007	7/17/2007	7/30/2007	0
EVANS MEMORIAL HOSPITAL	3/8/2006	9/1/2006	12/16/2006	9/15/2006	11/3/2006	0
FAIRVIEW PARK HOSPITAL	1/26/2007	2/1/2007	12/6/2006	6/1/2006	7/21/2006	0
FAYETTE COMMUNITY HOSPITAL	5/1/2006	6/1/2006	12/8/2006	6/6/2006	6/23/2006	0
FLINT RIVER HOSPITAL	4/3/2006	6/1/2006	12/6/2006	6/2/2006	6/29/2006	0
GORDON HOSPITAL	12/21/2006	1/1/2007	12/7/2006	6/17/2006	9/7/2006	0
HENRY MEDICAL CENTER	5/15/2006	6/1/2006	12/15/2006	6/3/2006	6/29/2006	0
HIGGINS GENERAL HOSPITAL	3/1/2007	3/1/2007	12/9/2006	6/4/2006	7/5/2006	0
HUGHSTON ORTHOPEDIC HOSPITAL	5/31/2006	6/1/2006	12/11/2006	7/1/2006	8/15/2006	0
IRWIN COUNTY HOSPITAL	3/7/2006	9/1/2006	12/8/2006	9/15/2006	10/10/2006	0
JEFF DAVIS HOSPITAL	4/20/2006	6/1/2006	12/6/2006	6/19/2006	8/24/2006	0
JOAN GLANCY HOSPITAL	6/7/2006	10/1/2006	2/8/2007	1/31/2007	2/15/2007	0
LIBERTY REGIONAL MEDICAL CENTER	3/8/2006	9/1/2006	12/13/2006	9/2/2006	11/7/2006	0
LOUIS SMITH MEMORIAL HOSPITAL	8/21/2006	9/1/2006	12/18/2006	12/1/2006	12/27/2006	0
MINNIE G BOWSELL MEMORIAL HOSPITAL	8/22/2006	9/1/2006	12/7/2006	9/3/2006	10/24/2006	0
MONROE COUNTY HOSPITAL	1/22/2006	6/1/2006	12/9/2006	6/18/2006	7/11/2006	0
MOUNTAIN LAKES MEDICAL CENTER	8/27/2006	9/1/2006	12/7/2006	8/28/2006	10/24/2006	0
MOUNTAINSIDE MEDICAL CENTER	5/1/2006	6/1/2006	12/8/2006	6/3/2006	7/14/2006	0
MURPHY MEDICAL CENTER	2/8/2007	3/1/2007	4/16/2007	9/26/2006	1/23/2007	0
MURRAY MEDICAL CENTER	8/27/2006	9/1/2006	12/14/2006	9/1/2006	10/12/2006	0
NEWNAN HOSPITAL	4/20/2006	6/1/2006	12/9/2006	6/3/2006	7/5/2006	0
NORTH FULTON REGIONAL HOSPITAL	4/20/2006	6/1/2006	12/8/2006	6/2/2006	6/20/2006	0
NORTHLAKE MEDICAL CENTER	5/23/2006	6/1/2006	12/6/2006	6/7/2006	7/27/2006	0
NORTHSIDE HOSPITAL	1/30/2006	6/1/2006	12/7/2006	6/1/2006	7/6/2006	0
NORTHSIDE HOSPITAL - FORSYTH	5/9/2006	6/1/2006	12/7/2006	6/21/2006	7/14/2006	0
NORTHSIDE HOSPITAL CHEROKEE	5/9/2006	6/1/2006	12/7/2006	6/5/2006	7/7/2006	0
PARKRIDGE MEDICAL CENTER	8/27/2006	9/1/2006	12/6/2006	9/1/2006	10/17/2006	0
PEACH REGIONAL MEDICAL CENTER	4/20/2006	6/1/2006	12/6/2006	6/10/2006	7/28/2006	0
PIEDMONT HOSPITAL	4/28/2006	6/1/2006	12/9/2006	6/10/2006	8/17/2006	0
PUTNAM GENERAL HOSPITAL	4/10/2007	5/1/2007	12/9/2006	7/31/2006	9/19/2006	0
ROCKDALE MEDICAL CENTER	4/24/2006	6/1/2006	12/7/2006	6/1/2006	7/11/2006	0
SE GEORGIA HEALTH SYSTEM-CAMDEN CAMPUS	8/15/2006	9/1/2006	12/8/2006	9/13/2006	10/10/2006	0
SMITH NORTHVIEW HOSPITAL	8/16/2006	9/1/2006	12/12/2006	7/30/2006	9/14/2006	0
SOUTH FULTON MEDICAL CENTER	4/20/2006	6/1/2006	12/6/2006	6/1/2006	6/27/2006	0

Georgia Department of Community Health
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Exhibit 1f - WellCare - Non-CHOA Hospital Contracting Timeliness

Provider Name	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	First Claim Received Date	First Date of Service	First Claim Paid Date	Number of Days After Effective Date of Participating Status to Date Provider Contract Was Entered
SOUTHWEST GA REG MEDICAL	9/18/2007	10/1/2007	2/27/2007	9/30/2006	3/6/2007	0
SPALDING REGIONAL MEDICAL CENTER	1/29/2006	6/1/2006	12/6/2006	6/3/2006	6/20/2006	0
ST JOSEPHS HOSPITAL	8/15/2006	9/1/2006	12/14/2006	6/6/2006	10/13/2006	0
STEWART WEBSTER HOSPITAL	8/21/2006	9/1/2006	12/14/2006	6/9/2006	12/12/2006	0
SYLVAN GROVE HOSPITAL	4/6/2006	6/1/2006	12/8/2006	6/1/2006	8/18/2006	0
TANNER MEDICAL CENTER	3/1/2007	3/1/2007	12/6/2006	6/2/2006	8/3/2006	0
TANNER MEDICAL CTR - VILLA RICA	3/1/2007	3/1/2007	12/6/2006	6/5/2006	7/5/2006	0
TATTNALL COMMUNITY HOSPITAL	1/23/2007	2/1/2007	1/8/2007	9/1/2006	9/28/2006	0
TAYLOR REGIONAL HOSPITAL	6/1/2006	6/1/2006	12/9/2006	6/4/2006	7/28/2006	0
TAYLOR-TELFAIR REGIONAL HOSPITAL	4/20/2006	6/1/2006	12/21/2006	6/1/2006	8/15/2006	0
TCT CHILDRENS HOSPITAL	7/11/2007	8/1/2007	12/13/2006	9/3/2006	12/21/2006	0
THE MEDICAL CENTER	6/26/2007	7/1/2007	12/5/2006	6/1/2006	6/20/2006	0
UNION GENERAL HOSPITAL	8/26/2006	9/1/2006	12/19/2006	9/1/2006	11/2/2006	0
UPSON REGIONAL MEDICAL CENTER	2/8/2006	6/1/2006	12/7/2006	6/1/2006	6/22/2006	0
WARM SPRINGS MEDICAL CENTER	5/16/2006	6/1/2006	12/7/2006	6/1/2006	7/14/2006	0
WAYNE MEMORIAL HOSPITAL	4/20/2006	6/1/2006	12/8/2006	9/1/2006	9/26/2006	0
WESLEY WOODS HOSPITAL	5/23/2006	6/1/2006	1/3/2007	12/16/2006	1/9/2007	0
WHEELER COUNTY HOSPITAL	4/20/2006	6/1/2006	12/11/2006	8/10/2006	8/29/2006	0

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Dates represent the actual dates provided by the CMOs. See report for comments regarding accuracy of dates being reports.

% of providers with contract entered into system prior to effective date of participating status 52.60%
Average number of days after effective date of participating status to date provider contract was entered: 46

Georgia Department of Community Health
Georgia Families
Exhibit 2a - AMERIGROUP - CHOA Hospital Credentialing Timeliness
AMERIGROUP did not provide credentialling dates for providers.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Children's Healthcare of Atlanta at Egleston	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Children's Healthcare of Atlanta at Scottish Rite	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A

Percentage of CHOA facilities credentialed before effective date of In-Network status	N/A
Percentage of CHOA facilities credentialed after effective date of In-Network status	N/A
Overall average number of days from application date to credentialing date	N/A

Dates represent the actual dates provided by the CMOs. See report for comments regarding reliability of data.

Georgia Department of Community Health
Georgia Families
Exhibit 2b - AMERIGROUP - Non-CHOA Hospital Credentialing Timeliness
Amerigroup did not provide credentialling dates for providers.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Anchor Hospital	N/A	N/A	10/12/2006	9/1/2006	N/A	N/A
Appling Healthcare System	N/A	N/A	10/2/2006	9/25/2006	N/A	N/A
Athens Regional Medical Ctr	N/A	N/A	2/14/2007	11/7/2006	N/A	N/A
Barrow Regional Medical Ctr	N/A	N/A	10/12/2006	9/1/2006	N/A	N/A
BJC Medical Center	N/A	N/A	9/22/2006	9/6/2006	N/A	N/A
Burke Medical Center	N/A	N/A	10/12/2006	9/1/2006	N/A	N/A
Candler County Hospital	N/A	N/A	10/16/2006	9/1/2006	N/A	N/A
Candler Hospital	N/A	N/A	12/18/2006	9/1/2006	N/A	N/A
Cartersville Medical Center	N/A	N/A	11/20/2006	9/1/2006	N/A	N/A
Charlton Memorial Hospital	N/A	N/A	10/11/2006	9/1/2006	N/A	N/A
Chatuge Regional Hospital	N/A	N/A	11/1/2006	9/1/2006	N/A	N/A
Chestatee Regional Hospital	N/A	N/A	11/7/2006	9/1/2006	N/A	N/A
Cobb Memorial Hospital	N/A	N/A	10/24/2006	9/1/2006	N/A	N/A
Doctors Hospital of Augusta	N/A	N/A	11/20/2006	9/1/2006	N/A	N/A
East Georgia Regional Medical Ctr	N/A	N/A	2/7/2007	2/6/2007	N/A	N/A
Effingham Hospital	N/A	N/A	10/12/2006	9/1/2006	N/A	N/A
Elbert Memorial Hospital	N/A	N/A	6/3/2006	6/1/2006	N/A	N/A
Emanuel Medical Ctr	N/A	N/A	10/24/2006	9/1/2006	N/A	N/A
Emory Adventist Hospital	N/A	N/A	4/27/2006	4/1/2006	N/A	N/A
Emory Crawford Long Hospital	N/A	N/A	4/25/2006	4/1/2006	N/A	N/A
Emory Eastside Medical Center	N/A	N/A	11/20/2006	9/1/2006	N/A	N/A
Emory Johns Creek Hospital	N/A	N/A	9/4/2007	1/18/2007	N/A	N/A
Emory University Hospital	N/A	N/A	4/25/2006	4/1/2006	N/A	N/A
Evans Memorial Hospital	N/A	N/A	10/2/2006	9/15/2006	N/A	N/A
Fannin Regional Hospital	N/A	N/A	9/11/2006	9/1/2006	N/A	N/A
Grady Memorial Hospital	N/A	N/A	5/11/2006	4/1/2006	N/A	N/A
Gwinnett Hospital Systems	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Habersham County Medical Ctr	N/A	N/A	8/16/2006	6/21/2006	N/A	N/A
Hamilton Medical Ctr	N/A	N/A	3/26/2007	12/1/2006	N/A	N/A
Hart County Hospital	N/A	N/A	10/24/2006	9/1/2006	N/A	N/A
Henry Medical Center	N/A	N/A	4/10/2006	4/1/2006	N/A	N/A
Higgins General Hospital	N/A	N/A	7/31/2006	6/1/2006	N/A	N/A
Hughes Spalding Children's Hospital	N/A	N/A	7/11/2006	6/1/2006	N/A	N/A
Hutcheson Medical Ctr	N/A	N/A	10/24/2006	9/1/2006	N/A	N/A
Jasper Memorial Hospital	N/A	N/A	6/7/2006	6/1/2006	N/A	N/A

Georgia Department of Community Health
Georgia Families
Exhibit 2b - AMERIGROUP - Non-CHOA Hospital Credentialing Timeliness
Amerigroup did not provide credentialling dates for providers.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
Jeff Davis Hospital	N/A	N/A	10/2/2006	9/27/2006	N/A	N/A
Jefferson Hospital	N/A	N/A	7/28/2006	6/1/2006	N/A	N/A
Jenkins County Hospital	N/A	N/A	10/17/2006	9/1/2006	N/A	N/A
Joan Glancy Memorial Hospital	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Legacy Medical Center of Atlanta	N/A	N/A	11/14/2006	11/3/2006	N/A	N/A
Liberty Regional Medical Ctr	N/A	N/A	9/22/2006	9/14/2006	N/A	N/A
McDuffie County Hospital	N/A	N/A	1/22/2007	12/1/2006	N/A	N/A
Meadows Regional Medical Ctr	N/A	N/A	10/17/2006	9/1/2006	N/A	N/A
Medical College of GA	N/A	N/A	9/6/2006	9/1/2006	N/A	N/A
Memorial Health University Medical Ctr	N/A	N/A	8/31/2006	9/1/2006	N/A	N/A
Minnie G. Boswell Memorial Hospital	N/A	N/A	10/24/2006	9/1/2006	N/A	N/A
Morgan Memorial Hospital	N/A	N/A	10/17/2006	9/1/2006	N/A	N/A
Mountain Lakes Medical Ctr	N/A	N/A	11/14/2006	11/10/2006	N/A	N/A
Murray Medical Center	N/A	N/A	3/20/2007	12/1/2006	N/A	N/A
Newton Medical Ctr	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
North Georgia Medical Ctr	N/A	N/A	10/2/2006	9/9/2006	N/A	N/A
Northeast Georgia Medical Center	N/A	N/A	9/18/2006	9/1/2006	N/A	N/A
Northeast Georgia Medical Ctr-Lanier Park	N/A	N/A	9/18/2006	9/1/2006	N/A	N/A
Northside Hospital	N/A	N/A	4/25/2006	4/1/2006	N/A	N/A
Northside Hospital-Cherokee	N/A	N/A	4/25/2006	4/1/2006	N/A	N/A
Northside Hospital-Forsyth	N/A	N/A	4/25/2006	4/1/2006	N/A	N/A
Piedmont Fayette Hospital	N/A	N/A	5/19/2006	4/1/2006	N/A	N/A
Piedmont Hospital	N/A	N/A	5/19/2006	4/1/2006	N/A	N/A
Piedmont Mountainside Hospital	N/A	N/A	5/19/2006	4/1/2006	N/A	N/A
Piedmont Newnan Hospital	N/A	N/A	10/9/2006	9/18/2006	N/A	N/A
Polk Medical Center	N/A	N/A	12/4/2006	9/1/2006	N/A	N/A
Putnam General Hospital	N/A	N/A	10/12/2006	9/1/2006	N/A	N/A
Redmond Regional Medical Ctr	N/A	N/A	8/24/2007	9/1/2006	N/A	N/A
Rockdale Medical Center	N/A	N/A	6/12/2006	6/1/2006	N/A	N/A
Satilla Regional Med Center	N/A	N/A	12/20/2006	9/1/2006	N/A	N/A
Screven County Hospital	N/A	N/A	10/11/2006	9/1/2006	N/A	N/A
Shepherd Ctr	N/A	N/A	6/8/2006	6/1/2006	N/A	N/A
Southeast Georgia Health System - Brunswick Campus	N/A	N/A	12/20/2006	12/19/2006	N/A	N/A
Southeast Georgia Health System - Camden Campus	N/A	N/A	12/20/2006	12/20/2006	N/A	N/A
Southern Regional Medical Ctr	N/A	N/A	7/3/2006	6/1/2006	N/A	N/A

Georgia Department of Community Health
Georgia Families
Exhibit 2b - AMERIGROUP - Non-CHOA Hospital Credentialing Timeliness
Amerigroup did not provide credentialling dates for providers.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
St Joseph's Hospital	N/A	N/A	12/18/2006	9/1/2006	N/A	N/A
St Joseph's Hospital of Atlanta	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
St Mary's Hospital	N/A	N/A	10/24/2006	9/1/2006	N/A	N/A
Stephens County Hospital	N/A	N/A	8/9/2006	8/1/2006	N/A	N/A
Tanner Medical Center Carrollton	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Tanner Medical Center - Villa Rica	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Tattnall Community Hospital	N/A	N/A	9/18/2006	9/1/2006	N/A	N/A
Union General Hospital	N/A	N/A	11/28/2006	9/9/2006	N/A	N/A
University Hospital	N/A	N/A	8/31/2006	9/1/2006	N/A	N/A
Walton Regional Medical Ctr	N/A	N/A	10/11/2006	9/1/2006	N/A	N/A
Washington County Regional Medical Ctr	N/A	N/A	5/2/2007	4/1/2007	N/A	N/A
Wayne Memorial Hospital	N/A	N/A	10/12/2006	9/1/2006	N/A	N/A
Wellstar Cobb Hospital	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Wellstar Douglas Hospital	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Wellstar Kennestone Hospital	N/A	N/A	7/21/2006	6/1/2006	N/A	N/A
WellStar Paulding Hospital	N/A	N/A	7/20/2006	6/1/2006	N/A	N/A
Wellstar Windy Hill Hospital	N/A	N/A	7/21/2006	6/1/2006	N/A	N/A
Wesley Woods Center of Emory University	N/A	N/A	4/27/2006	4/1/2006	N/A	N/A
Wills Memorial Hospital	N/A	N/A	12/11/2006	12/11/2006	N/A	N/A

Percentage of facilities credentialed before effective date of In-Network status	N/A
Percentage of facilities credentialed after effective date of In-Network status	N/A
Overall average number of days from application date to credentialing date	N/A

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Dates represent the actual dates provided by the CMOs. See report for comments regarding reliability of data.
Duplicate names may indicate the provider has multiple locations

Georgia Department of Community Health
Georgia Families
Exhibit 2c - Peach State Health Plan - CHOA Hospital Credentialing Timeliness

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
CHILDRENS HLTH CARE OF ATL EGLESTON	4/26/2006	6/1/2006	N/A	6/1/2006	36	0
SCOTTISH RITE CHILDRENS MED CTR	6/1/2006	6/1/2006	N/A	6/1/2006	0	0

Percentage of CHOA facilities credentialed on/before effective date of In-Network status	100%
Percentage of CHOA facilities credentialed after effective date of In-Network status	0%
Overall average number of days from application date to credentialing date	18

Dates represent the actual dates provided by the CMOs. See report for comments regarding reliability of data.
Peach State did not provide the date the provider was entered into the system as an In-Network Provider

Georgia Department of Community Health
Georgia Families
Exhibit 2d - Peach State Health Plan - Non-CHOA Hospital Credentialing Timeliness
See notes at end of section.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
TIFT GENERAL MEDICAL CENTER	7/27/2007	9/28/2007	N/A	9/1/2006	63	392
TAYLOR TELFAIR REGIONAL HOSPITAL	2/27/2007	6/20/2007	N/A	6/1/2006	113	384
GWINNETT MEDICAL CENTER	4/28/2006	6/1/2007	N/A	6/1/2006	399	365
JOAN GLANCY MEMORIAL HOSPITAL	4/28/2006	6/1/2007	N/A	6/1/2006	399	365
MILLER COUNTY HOSPITAL	6/5/2006	3/15/2007	N/A	6/1/2006	283	287
GORDON HOSPITAL	10/2/2006	12/19/2006	N/A	6/1/2006	78	201
EFFINGHAM HOSP & CARE CTR	10/19/2006	12/14/2006	N/A	6/1/2006	56	196
CLINCH MEMORIAL HOSPITAL	10/2/2006	2/21/2007	N/A	9/1/2006	142	173
POLK MEDICAL CENTER	9/25/2006	10/11/2006	N/A	6/1/2006	16	132
REDMOND REGIONAL MEDICAL CENTER	9/25/2006	10/11/2006	N/A	6/1/2006	16	132
WASHINGTON CNTY REGIONAL MED CENTER	9/19/2006	9/23/2006	N/A	6/1/2006	4	114
LIBERTY REGIONAL MEDICAL CENTER	9/6/2006	9/8/2006	N/A	6/1/2006	2	99
FLOYD MEDICAL CENTER	3/1/2006	6/1/2007	N/A	3/1/2007	457	92
PHOEBE PUTNEY MEMORIAL HOSPITAL	8/28/2006	9/1/2006	N/A	6/1/2006	4	92
PHOEBE PUTNEY MEMORIAL HOSPITAL	8/28/2006	9/1/2006	N/A	6/1/2006	4	92
BACON COUNTY HOSPITAL	7/18/2006	8/30/2006	N/A	6/1/2006	43	90
SCREVEN COUNTY HOSPITAL	8/8/2006	8/30/2006	N/A	6/1/2006	22	90
NORTHSIDE HOSPITAL	8/15/2006	8/30/2006	N/A	6/1/2006	15	90
NORTHSIDE HOSPITAL-FORSYTH	8/15/2006	8/30/2006	N/A	6/1/2006	15	90
EVANS MEMORIAL HOSP INC	1/16/2006	8/16/2006	N/A	6/1/2006	212	76
JASPER MEMORIAL HOSPITAL AND REHAB	6/10/2006	8/16/2006	N/A	6/1/2006	67	76
GEORGE H LANIER MEMORIAL HOSPITAL	8/14/2006	8/16/2006	N/A	6/1/2006	2	76
SMITH NORTHVIEW HOSPITAL	8/14/2006	8/16/2006	N/A	6/1/2006	2	76
ST JOSEPH HOSPITAL OF ATLANTA	8/14/2006	8/16/2006	N/A	6/1/2006	2	76
COLISEUM MEDICAL CENTER	7/31/2006	8/2/2006	N/A	6/1/2006	2	62
FAIRVIEW PARK HOSPITAL	7/31/2006	8/2/2006	N/A	6/1/2006	2	62
PALMYRA MEDICAL CENTER	7/31/2006	8/2/2006	N/A	6/1/2006	2	62
COLISEUM NORTHSIDE HOSPITAL	3/29/2006	7/19/2006	N/A	6/1/2006	112	48
HUGHSTON SPORTS MEDICINE HOSPITAL	3/29/2006	7/19/2006	N/A	6/1/2006	112	48
DOCTORS HOSPITAL OF COLUMBUS	4/19/2006	7/19/2006	N/A	6/1/2006	91	48
SOUTHERN REGIONAL MEDICAL CENTER	6/14/2006	7/19/2006	N/A	6/1/2006	35	48
HOUSTON MEDICAL CENTER	5/22/2006	7/18/2006	N/A	6/1/2006	57	47
PERRY HOSPITAL	5/22/2006	7/18/2006	N/A	6/1/2006	57	47
DONALSONVILLE HOSPITAL	9/13/2006	9/30/2006	N/A	9/1/2006	17	29
SATILLA REGIONAL MEDICAL CTR	9/15/2006	9/23/2006	N/A	9/1/2006	8	22
BROOKS COUNTY HOSPITAL	9/19/2006	9/23/2006	N/A	9/1/2006	4	22
NORTHSIDE HOSPITAL- CHEROKEE	6/20/2006	6/21/2006	N/A	6/1/2006	1	20
NEWTON MEDICAL CENTER	4/11/2006	6/7/2006	N/A	6/1/2006	57	6

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Exhibit 2d - Peach State Health Plan - Non-CHOA Hospital Credentialing Timeliness
See notes at end of section.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
BARROW REGIONAL MEDICAL CENTER	6/5/2006	6/7/2006	N/A	6/1/2006	2	6
PIEDMONT FAYETTE HOSPITAL	6/5/2006	6/7/2006	N/A	6/1/2006	2	6
PIEDMONT MOUNTAINSIDE HOSPITAL	6/5/2006	6/7/2006	N/A	6/1/2006	2	6
WALTON MEDICAL CENTER	9/7/2005	4/28/2006	N/A	6/1/2006	233	0
COFFEE REGIONAL MEDICAL CTR	11/1/2005	4/28/2006	N/A	6/1/2006	178	0
COFFEE REGIONAL MEDICAL CTR	11/1/2005	4/28/2006	N/A	6/1/2006	178	0
CRISP REGIONAL HOSP	11/9/2005	4/12/2006	N/A	6/1/2006	154	0
SOUTHEAST ALABAMA MED CTR	10/2/2006	1/17/2007	N/A	2/1/2007	107	0
TAYLOR REGIONAL HOSPITAL	10/14/2005	1/25/2006	N/A	6/1/2006	103	0
ATLANTA MEDICAL CENTER-TENET	3/1/2006	6/1/2006	N/A	6/1/2006	92	0
MEDICAL CENTER INC	3/1/2006	6/1/2006	N/A	6/1/2006	92	0
MEDICAL CENTER OF CENTRAL GA	3/1/2006	6/1/2006	N/A	6/1/2006	92	0
PEACH REGIONAL MEDICAL CENTER	3/1/2006	6/1/2006	N/A	6/1/2006	92	0
PEACH REGIONAL MEDICAL CENTER	3/1/2006	6/1/2006	N/A	6/1/2006	92	0
MEMORIAL HEALTH UNIVERSITY MED CTR	12/21/2006	2/21/2007	N/A	3/1/2007	62	0
ROCKDALE MEDICAL CENTER	1/6/2006	2/22/2006	N/A	6/1/2006	47	0
ARCHBOLD MEDICAL CENTER	7/18/2006	9/1/2006	N/A	9/1/2006	45	0
EARLY MEMORIAL HOSPITAL	7/18/2006	9/1/2006	N/A	9/1/2006	45	0
GRADY GENERAL HOSPITAL	7/18/2006	9/1/2006	N/A	9/1/2006	45	0
EMORY UNIVERSITY HOSPITAL	4/25/2006	6/1/2006	N/A	6/1/2006	37	0
CHILDRENS HLTH CARE OF ATL EGLESTON	4/26/2006	6/1/2006	N/A	6/1/2006	36	0
FLINT RIVER COMMUNITY HOSP	4/21/2006	5/24/2006	N/A	6/1/2006	33	0
WAYNE MEMORIAL HOSPITAL	2/15/2006	3/17/2006	N/A	6/1/2006	30	0
NORTH FULTON REGION HOSP TENET	3/29/2006	4/28/2006	N/A	6/1/2006	30	0
SOUTH FULTON MEDICAL CTR TENET	3/29/2006	4/28/2006	N/A	6/1/2006	30	0
SPALDING REGIONAL HOSPITAL	3/29/2006	4/28/2006	N/A	6/1/2006	30	0
MEMORIAL HOSPITAL OF ADEL	8/1/2006	8/30/2006	N/A	9/1/2006	29	0
BLECKLEY MEMORIAL HOSPITAL	2/8/2006	2/22/2006	N/A	6/1/2006	14	0
CANDLER COUNTY HOSPITAL	2/8/2006	2/22/2006	N/A	6/1/2006	14	0
DODGE COUNTY HOSP	2/8/2006	2/22/2006	N/A	6/1/2006	14	0
DODGE COUNTY HOSP	2/8/2006	2/22/2006	N/A	6/1/2006	14	0
PUTNAM GENERAL HOSPITAL	2/8/2006	2/22/2006	N/A	6/1/2006	14	0
MONROE COUNTY HOSPITAL	2/10/2006	2/22/2006	N/A	6/1/2006	12	0
ELBERT MEMORIAL HOSPITAL	9/19/2006	9/30/2006	N/A	10/1/2007	11	0
ST FRANCIS HOSPITAL	12/8/2006	12/19/2006	N/A	1/1/2007	11	0
CHESTATEE REGIONAL HOSPITAL	9/19/2006	9/23/2006	N/A	10/10/2006	4	0
NORTH GEORGIA MEDICAL CENTER	9/19/2006	9/23/2006	N/A	10/10/2006	4	0
NORTH GEORGIA MEDICAL CENTER	9/19/2006	9/23/2006	N/A	10/1/2006	4	0

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Exhibit 2d - Peach State Health Plan - Non-CHOA Hospital Credentialing Timeliness
See notes at end of section.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
PHOEBE WORTH HOSPITAL	8/28/2006	9/1/2006	N/A	9/1/2006	4	0
SOUTHWEST GEORGIA REGIONAL	8/28/2006	9/1/2006	N/A	9/1/2006	4	0
CHARLTON MEMORIAL HOSPITAL	4/26/2006	4/28/2006	N/A	6/1/2006	2	0
HIGGINS GENERAL HOSPITAL	4/26/2006	4/28/2006	N/A	6/1/2006	2	0
ROOSEVELT WARM SPRINGS INST FOR REHA	4/27/2006	4/28/2006	N/A	6/1/2006	1	0
SUMTER REGIONAL HOSPITAL	8/31/2006	9/1/2006	N/A	9/1/2006	1	0
EMANUEL COUNTY HOSPITAL	8/3/2006	6/1/2006	N/A	2/1/2007	0	0
IRWIN COUNTY HOSPITAL	2/28/2006	2/22/2006	N/A	6/1/2006	0	0
JEFF DAVIS HOSPITAL	3/6/2006	2/22/2006	N/A	6/1/2006	0	0
WHEELER COUNTY HOSPITAL	6/7/2006	4/28/2006	N/A	6/1/2006	0	0
BERRIEN COUNTY HOSPITAL	N/A	N/A	N/A	9/1/2006	N/A	N/A
CALHOUN MEMORIAL HOSPITAL	N/A	N/A	N/A	9/1/2006	N/A	N/A
CARTERSVILLE MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
COLQUITT REGIONAL HOSPITAL	N/A	N/A	N/A	9/1/2006	N/A	N/A
DECATUR HOSPITAL	N/A	N/A	N/A	6/1/2006	N/A	N/A
DEKALB MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
DEKALB MEDICAL CENTER AT HILLANDALE	N/A	N/A	N/A	6/1/2006	N/A	N/A
DORMINY MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
EMORY ADVENTIST HOSP	N/A	N/A	N/A	6/1/2006	N/A	N/A
EMORY CRAWFORD LONG HOSPITAL	N/A	N/A	N/A	6/1/2006	N/A	N/A
EMORY EASTSIDE MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
ERLANGER MEDICAL CENTER	N/A	N/A	N/A	7/1/2007	N/A	N/A
GRADY HEALTH SYSTEM	N/A	N/A	N/A	6/1/2006	N/A	N/A
HABERSHAM COUNTY MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
HENRY MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
HUGHES SPALDING CHILDRENS HOSP	N/A	N/A	N/A	6/1/2006	N/A	N/A
LOUIS SMITH MEMORIAL HOSPITAL	N/A	N/A	N/A	9/1/2006	N/A	N/A
MEDICAL COLLEGE OF GEORGIA HOSPITAL	N/A	N/A	N/A	3/1/2007	N/A	N/A
MEMORIAL HOSPITAL AND MANOR	N/A	N/A	N/A	9/1/2006	N/A	N/A
MITCHELL COUNTY HOSPITAL	N/A	N/A	N/A	9/1/2006	N/A	N/A
OCONEE REGIONAL MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
PIEDMONT HOSPITAL	N/A	N/A	N/A	6/1/2006	N/A	N/A
PIEDMONT NEWNAN HOSPITAL	N/A	N/A	N/A	3/1/2007	N/A	N/A
SHEPHERD CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
SOUTH GEORGIA MEDICAL CENTER	N/A	N/A	N/A	9/1/2006	N/A	N/A
SPECIALTY LABO	N/A	N/A	N/A	5/1/2007	N/A	N/A
ST MARYS HOSPITAL	N/A	N/A	N/A	3/1/2007	N/A	N/A
STEWART WEBSTER HOSPITAL	N/A	N/A	N/A	6/1/2006	N/A	N/A

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Exhibit 2d - Peach State Health Plan - Non-CHOA Hospital Credentialing Timeliness
See notes at end of section.

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
SYLVAN GROVE HOSPITAL TENET	N/A	N/A	N/A	6/1/2006	N/A	N/A
TANNER MEDICAL CENTER- VILLA RICA	N/A	N/A	N/A	6/1/2006	N/A	N/A
TANNER MEDICAL CENTER-CARROLLTON	N/A	N/A	N/A	7/1/2006	N/A	N/A
TCT CHILDRENS HOSPITAL	N/A	N/A	N/A	7/1/2007	N/A	N/A
UPSON REGIONAL MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
WARM SPRINGS MEDICAL CENTER	N/A	N/A	N/A	6/1/2006	N/A	N/A
WESLEY WOOD CTR OF EMORY UNIVERSITY	N/A	N/A	N/A	6/1/2006	N/A	N/A
WEST GEORGIA MEDICAL CTR	N/A	N/A	N/A	10/1/2006	N/A	N/A

Percentage of facilities credentialed on/before effective date of In-Network status	52.33%
Percentage of facilities credentialed after effective date of In-Network status	47.67%
Overall average number of days from application date to credentialing date	58
Average number of days after effective date to credentialing date	108

32 providers (37%) had In Network Provider Status effective dates prior to the CMO-reported application date. See report for comments regarding reliability of data.

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Dates represent the actual dates provided by the CMOs. See report for comments regarding reliability of data.
If the CMO reported an application date that appeared to be after the credentialing date then the number of days between the two dates is reflected as zero.
Peach State did not provide the date the provider was entered into the system as an In-Network Provider
Duplicate names may indicate the provider has multiple locations

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Exhibit 2e - WellCare - CHOA Hospital Credentialing Timeliness

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
CHOA AT EGLESTON	N/A	3/13/2006	4/11/2007	1/15/2007	N/A	0
CHOA AT SCOTTISH RITE	N/A	5/25/2006	4/11/2007	1/15/2007	N/A	0

Percentage of CHOA facilities credentialed before effective date of In-Network status	100.00%
Percentage of CHOA facilities credentialed after effective date of In-Network status	0.00%
Overall average number of days from application date to credentialing date	N/A

Dates represent the actual dates provided by the CMOs. See report for comments regarding reliability of data.

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Exhibit 2f - WellCare - Non-CHOA Hospital Credentialing Timeliness

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
AUGUSTA HOSPITAL	N/A	3/5/2007	3/5/2007	10/1/2006	N/A	155
MEMORIAL NORTH PARK HOSPITAL	N/A	1/31/2007	1/31/2007	9/1/2006	N/A	152
PARKRIDGE MEDICAL CENTER	N/A	10/9/2006	8/27/2006	9/1/2006	N/A	38
PARKRIDGE EAST HOSPITAL	N/A	10/9/2006	10/9/2006	9/1/2006	N/A	38
PARKRIDGE VALLEY HOSPITAL	N/A	10/9/2006	10/9/2006	9/1/2006	N/A	38
LANIER HEALTH SERVICES	N/A	10/3/2006	10/3/2006	9/1/2006	N/A	32
DOCTORS HOSPITAL	N/A	6/26/2006	6/26/2006	6/1/2006	N/A	25
PALMYRA MEDICAL CENTERS	N/A	6/26/2006	6/26/2006	6/1/2006	N/A	25
POLK MEDICAL CENTER	N/A	6/26/2006	6/26/2006	6/1/2006	N/A	25
WASHINGTON COUNTY REGIONAL MEDICAL CTR	N/A	9/22/2006	9/22/2006	9/1/2006	N/A	21
REDMOND REGIONAL MEDICAL CTR	N/A	6/22/2006	6/26/2006	6/1/2006	N/A	21
WILLS MEMORIAL HOSPITAL	N/A	9/21/2006	9/21/2006	9/1/2006	N/A	20
HAMILTON MEDICAL CENTER	N/A	9/20/2006	9/20/2006	9/1/2006	N/A	19
CHATUGE REGIONAL HOSPITAL INC	N/A	9/13/2006	9/13/2006	9/1/2006	N/A	12
FANNIN REGIONAL HOSPITAL	N/A	9/8/2006	9/8/2006	9/1/2006	N/A	7
NORTHEAST GEORGIA MED CTR-LANIER PARK	N/A	9/5/2006	9/5/2006	9/1/2006	N/A	4
WALTON REGIONAL MEDICAL CTR	N/A	6/5/2006	6/5/2006	6/1/2006	N/A	4
MEMORIAL HOSPITAL AND MANOR	N/A	10/4/2007	10/4/2007	10/1/2007	N/A	3
FLOYD MEDICAL CENTER	N/A	5/9/2007	5/9/2007	5/8/2007	N/A	1
TAYLOR REGIONAL HOSPITAL	N/A	6/1/2006	6/1/2006	6/1/2006	N/A	0
HUGHES SPALDING CHILDRENS HOSPITAL	N/A	6/2/2006	7/5/2006	6/2/2006	N/A	0
HUGHSTON ORTHOPEDIC HOSPITAL	N/A	5/31/2006	5/31/2006	6/1/2006	N/A	0
MOUNTAIN LAKES MEDICAL CENTER	N/A	8/27/2006	8/27/2006	9/1/2006	N/A	0
STEPHENS COUNTY HOSPITAL	N/A	8/26/2006	9/7/2006	9/1/2006	N/A	0
COLISEUM NORTHSIDE HOSPITAL	N/A	5/25/2006	5/25/2006	6/1/2006	N/A	0
EMORY UNIVERSITY HOSPITAL - MAIN	N/A	5/23/2006	5/23/2006	6/1/2006	N/A	0
NORTHLAKE MEDICAL CENTER	N/A	5/23/2006	5/23/2006	6/1/2006	N/A	0
WESLEY WOODS HOSPITAL	N/A	5/23/2006	5/23/2006	6/1/2006	N/A	0
MINNIE G BOWSELL MEMORIAL HOSPITAL	N/A	8/22/2006	8/22/2006	9/1/2006	N/A	0
COBB MEMORIAL HOSPITAL	N/A	8/22/2006	9/12/2006	9/1/2006	N/A	0
LOUIS SMITH MEMORIAL HOSPITAL	N/A	8/21/2006	8/21/2006	9/1/2006	N/A	0
STEWART WEBSTER HOSPITAL	N/A	8/21/2006	8/21/2006	9/1/2006	N/A	0
EAST GEORGIA REGIONAL MEDICAL CTR	N/A	12/20/2006	12/20/2006	1/1/2007	N/A	0
BERRIEN COUNTY HOSPITAL	N/A	8/16/2006	8/16/2006	9/1/2006	N/A	0
COLQUITT REGIONAL MEDICAL CTR	N/A	8/16/2006	8/16/2006	9/1/2006	N/A	0
COPPER BASIN MEDICAL CENTER	N/A	1/16/2007	1/16/2007	2/1/2007	N/A	0
DONALSONVILLE HOSPITAL	N/A	8/16/2006	8/16/2006	9/1/2006	N/A	0
EMORY-ADVENTIST HOSPITAL	N/A	5/16/2006	5/16/2006	6/1/2006	N/A	0

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Exhibit 2f - WellCare - Non-CHOA Hospital Credentialing Timeliness

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
WARM SPRINGS MEDICAL CENTER	N/A	5/16/2006	5/16/2006	6/1/2006	N/A	0
HENRY MEDICAL CENTER	N/A	5/15/2006	5/15/2006	6/1/2006	N/A	0
SE GEORGIA HEALTH SYSTEM-CAMDEN CAMPUS	N/A	8/15/2006	8/15/2006	9/1/2006	N/A	0
CANDLER HOSPITAL	N/A	8/15/2006	9/27/2006	9/1/2006	N/A	0
BJC MEDICAL CENTER	N/A	8/14/2006	9/29/2006	9/1/2006	N/A	0
BLEDSOE HOSPITAL	N/A	6/12/2007	6/13/2007	7/1/2007	N/A	0
ANGEL MEDICAL CENTER	N/A	2/8/2007	2/8/2007	3/1/2007	N/A	0
ERLANGER NORTH HOSPITAL	N/A	7/11/2007	7/11/2007	8/1/2007	N/A	0
MURPHY MEDICAL CENTER	N/A	2/8/2007	2/8/2007	3/1/2007	N/A	0
HABERSHAM COUNTY MEDICAL CENTER	N/A	8/11/2006	9/13/2006	9/1/2006	N/A	0
APPLING HEALTHCARE SYSTEM	N/A	8/10/2006	9/12/2006	9/1/2006	N/A	0
DORMINY MEDICAL CENTER	N/A	8/10/2006	9/25/2006	9/1/2006	N/A	0
NORTHSIDE HOSPITAL CHEROKEE	N/A	5/9/2006	5/9/2006	6/1/2006	N/A	0
MEMORIAL HEALTH UNIVERSITY MED CTR	N/A	8/9/2006	9/12/2006	9/1/2006	N/A	0
FAYETTE COMMUNITY HOSPITAL	N/A	5/1/2006	5/1/2006	6/1/2006	N/A	0
MOUNTAINSIDE MEDICAL CENTER	N/A	5/1/2006	5/1/2006	6/1/2006	N/A	0
MEMORIAL HOSPITAL OF ADEL	N/A	8/1/2006	9/19/2006	9/1/2006	N/A	0
PIEDMONT HOSPITAL	N/A	4/28/2006	4/28/2006	6/1/2006	N/A	0
ROCKDALE MEDICAL CENTER	N/A	4/24/2006	4/24/2006	6/1/2006	N/A	0
BARROW REGIONAL MEDICAL CTR	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
JEFF DAVIS HOSPITAL	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
NEWNAN HOSPITAL	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
NORTH FULTON REGIONAL HOSPITAL	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
PEACH REGIONAL MEDICAL CENTER	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
TAYLOR-TELFAIR REGIONAL HOSPITAL	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
WAYNE MEMORIAL HOSPITAL	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
WHEELER COUNTY HOSPITAL	N/A	4/20/2006	4/20/2006	6/1/2006	N/A	0
MORGAN MEMORIAL HOSPITAL	N/A	7/19/2006	11/1/2006	9/1/2006	N/A	0
CALHOUN MEMORIAL HOSPTIAL	N/A	2/13/2007	2/14/2007	4/1/2007	N/A	0
ATHENS REGIONAL MEDICAL CENTER	N/A	6/29/2006	9/8/2006	9/1/2006	N/A	0
CHESTATEE REGIONAL HOSPITAL	N/A	6/29/2006	9/15/2006	9/1/2006	N/A	0
TIFT REGIONAL MEDICAL CENTER	N/A	6/27/2006	9/27/2006	9/1/2006	N/A	0
MEADOWS REGIONAL MEDICAL CENTER	N/A	6/21/2006	9/28/2006	9/1/2006	N/A	0
ST MARYS HEALTH CARE SYSTEM	N/A	6/20/2006	10/30/2006	9/1/2006	N/A	0
NORTHEAST GEORGIA MEDICAL CENTER	N/A	6/19/2006	9/2/2006	9/1/2006	N/A	0
JEFFERSON HOSPITAL	N/A	9/18/2006	1/4/2007	12/1/2006	N/A	0
EARLY MEMORIAL HOSPITAL	N/A	8/16/2006	11/14/2006	11/1/2006	N/A	0
SYLVAN GROVE HOSPITAL	N/A	3/13/2006	4/6/2006	6/1/2006	N/A	0

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Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
EMORY EASTSIDE MEDICAL CTR	N/A	3/13/2006	5/31/2006	6/1/2006	N/A	0
JOHN D ARCHBOLD MEMORIAL HOSP	N/A	7/28/2006	11/14/2006	11/1/2006	N/A	0
MEMORIAL HOSPITAL	N/A	5/23/2006	1/31/2007	9/1/2006	N/A	0
ST JOSEPHS HOSPITAL	N/A	5/20/2006	8/15/2006	9/1/2006	N/A	0
COFFEE REGIONAL MEDICAL CENTER	N/A	2/14/2006	2/14/2006	6/1/2006	N/A	0
CRISP REGIONAL HOSPITAL	N/A	2/8/2006	2/8/2006	6/1/2006	N/A	0
UPSON REGIONAL MEDICAL CENTER	N/A	2/8/2006	2/8/2006	6/1/2006	N/A	0
MILLER COUNTY HOSPITAL	N/A	8/10/2006	1/6/2007	12/1/2006	N/A	0
COLISEUM MEDICAL CENTERS	N/A	2/7/2006	2/7/2006	6/1/2006	N/A	0
HUTCHESON MED CENTER	N/A	8/9/2006	1/2/2007	12/1/2006	N/A	0
CARTERSVILLE MEDICAL CENTER	N/A	2/1/2006	2/1/2006	6/1/2006	N/A	0
JOAN GLANCY HOSPITAL	N/A	6/2/2006	6/7/2006	10/1/2006	N/A	0
SPALDING REGIONAL MEDICAL CENTER	N/A	1/29/2006	1/29/2006	6/1/2006	N/A	0
ATLANTA MEDICAL CENTER	N/A	1/26/2006	1/26/2006	6/1/2006	N/A	0
TATTNALL COMMUNITY HOSPITAL	N/A	9/25/2006	1/23/2007	2/1/2007	N/A	0
CLINCH MEMORIAL HOSPITAL	N/A	4/20/2006	9/18/2006	9/1/2006	N/A	0
ELBERT MEMORIAL HOSPITAL	N/A	4/4/2006	9/18/2006	9/1/2006	N/A	0
TCT CHILDRENS HOSPITAL	N/A	2/15/2007	7/11/2007	8/1/2007	N/A	0
BACON COUNTY HOSPITAL	N/A	3/14/2006	3/14/2006	9/1/2006	N/A	0
CANDLER COUNTY HOSPITAL	N/A	3/13/2006	3/13/2006	9/1/2006	N/A	0
DODGE COUNTY HOSPITAL	N/A	3/13/2006	3/13/2006	9/1/2006	N/A	0
EMORY CRAWFORD LONG HOSPITAL	N/A	3/13/2006	9/1/2006	9/1/2006	N/A	0
SATILLA REGIONAL MEDICAL CENTER	N/A	3/13/2006	10/6/2006	9/1/2006	N/A	0
SCREVEN COUNTY HOSPITAL	N/A	3/13/2006	11/14/2006	9/1/2006	N/A	0
EFFINGHAM HOSPITAL	N/A	3/9/2006	3/9/2006	9/1/2006	N/A	0
EVANS MEMORIAL HOSPITAL	N/A	3/8/2006	3/8/2006	9/1/2006	N/A	0
LIBERTY REGIONAL MEDICAL CENTER	N/A	3/8/2006	3/8/2006	9/1/2006	N/A	0
IRWIN COUNTY HOSPITAL	N/A	3/7/2006	3/7/2006	9/1/2006	N/A	0
GORDON HOSPITAL	N/A	6/19/2006	12/21/2006	1/1/2007	N/A	0
MCDUFFIE REGIONAL MEDICAL CENTER	N/A	10/13/2006	5/2/2007	5/1/2007	N/A	0
JASPER MEMORIAL HOSPITAL	N/A	5/10/2006	1/4/2007	12/1/2006	N/A	0
DOUGLAS HOSPITAL	N/A	6/1/2006	9/7/2007	1/1/2007	N/A	0
PAULDING HOSPITAL	N/A	6/1/2006	9/7/2007	1/1/2007	N/A	0
WINDY HILL HOSPITAL	N/A	6/1/2006	9/7/2007	1/1/2007	N/A	0
SOUTH GEORGIA MEDICAL CENTER	N/A	1/24/2006	9/19/2006	9/1/2006	N/A	0
NEWTON MEDICAL CENTER	N/A	5/19/2006	2/28/2007	1/2/2007	N/A	0
BROOKS COUNTY HOSPITAL	N/A	3/13/2006	11/15/2006	11/1/2006	N/A	0
WEST GEORGIA MEDICAL CENTER	N/A	2/6/2006	2/12/2007	10/1/2006	N/A	0

Georgia Department of Community Health
Georgia Families
Exhibit 2f - WellCare - Non-CHOA Hospital Credentialing Timeliness

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
SOUTH FULTON MEDICAL CENTER	N/A	9/29/2005	4/20/2006	6/1/2006	N/A	0
UNIVERSITY HOSPITAL	N/A	8/26/2006	5/2/2007	5/1/2007	N/A	0
JENKINS COUNTY HOSPITAL	N/A	8/23/2006	5/2/2007	5/1/2007	N/A	0
GWINNETT MEDICAL CENTER	N/A	1/26/2006	11/16/2006	11/1/2006	N/A	0
WELLSTAR COBB HOSPITAL	N/A	3/13/2006	9/7/2007	1/1/2007	N/A	0
DOCTORS HOSPITAL	N/A	7/8/2005	5/24/2006	6/1/2006	N/A	0
FAIRVIEW PARK HOSPITAL	N/A	2/6/2006	1/26/2007	2/1/2007	N/A	0
NORTHSIDE HOSPITAL	N/A	6/2/2005	1/30/2006	6/1/2006	N/A	0
PUTNAM GENERAL HOSPITAL	N/A	4/20/2006	4/10/2007	5/1/2007	N/A	0
MONROE COUNTY HOSPITAL	N/A	5/18/2005	1/22/2006	6/1/2006	N/A	0
UNION GENERAL HOSPITAL	N/A	8/9/2005	8/26/2006	9/1/2006	N/A	0
SOUTHERN REGIONAL MED CTR	N/A	6/3/2005	9/21/2006	7/1/2006	N/A	0
PERRY HOSPITAL	N/A	6/2/2006	8/25/2007	7/1/2007	N/A	0
GRADY MEMORIAL HOSPITAL	N/A	5/31/2006	9/6/2007	7/1/2007	N/A	0
HIGGINS GENERAL HOSPITAL	N/A	1/27/2006	3/1/2007	3/1/2007	N/A	0
TANNER MEDICAL CTR - VILLA RICA	N/A	1/27/2006	3/1/2007	3/1/2007	N/A	0
SOUTHWEST GA REG MEDICAL	N/A	8/21/2006	9/18/2007	10/1/2007	N/A	0
NORTHSIDE HOSPITAL - FORSYTH	N/A	3/24/2005	5/9/2006	6/1/2006	N/A	0
MURRAY MEDICAL CENTER	N/A	6/6/2005	8/27/2006	9/1/2006	N/A	0
ERLANGER BARONESS HOSPITAL	N/A	3/25/2006	6/20/2007	7/1/2007	N/A	0
NORTH GEORGIA MEDICAL CENTER	N/A	3/13/2006	8/17/2007	7/1/2007	N/A	0
BLECKLEY MEMORIAL HOSPITAL	N/A	1/31/2005	4/20/2006	6/1/2006	N/A	0
FLINT RIVER HOSPITAL	N/A	1/24/2005	4/3/2006	6/1/2006	N/A	0
OCONEE REG MEDICAL CENTER	N/A	2/6/2006	7/13/2007	7/1/2007	N/A	0
MITCHELL COUNTY HOSPITAL	N/A	5/22/2005	11/15/2006	11/1/2006	N/A	0
HOUSTON MEDICAL CENTER	N/A	2/2/2006	8/4/2007	8/1/2007	N/A	0
KENNESTONE HOSPITAL	N/A	6/27/2005	9/7/2007	1/1/2007	N/A	0
GRADY GENERAL HOSPITAL	N/A	4/26/2005	11/15/2006	11/1/2006	N/A	0
HART COUNTY HOSPITAL	N/A	2/23/2005	9/12/2006	9/1/2006	N/A	0
MEDICAL COLLEGE OF GEORGIA	N/A	3/10/2006	10/6/2007	10/1/2007	N/A	0
SMITH NORTHVIEW HOSPITAL	N/A	1/27/2005	8/16/2006	9/1/2006	N/A	0
SE GEORGIA HEALTH SYS-BRUNSWICK CAMPUS	N/A	1/27/2005	11/15/2006	9/1/2006	N/A	0
CHARLTON MEMORIAL HOSPITAL	N/A	1/18/2005	8/15/2006	9/1/2006	N/A	0
EMANUEL MEDICAL CENTER	N/A	8/30/2005	5/2/2007	5/1/2007	N/A	0
BURKE MEDICAL CENTER	N/A	5/18/2005	3/16/2007	4/1/2007	N/A	0
ERLANGER EAST HOSPITAL	N/A	6/24/2005	6/13/2007	7/1/2007	N/A	0
TANNER MEDICAL CENTER	N/A	2/7/2005	3/1/2007	3/1/2007	N/A	0
MEDICAL CENTER OF CENTRAL GEORGIA	N/A	5/13/2005	8/17/2007	7/1/2007	N/A	0

Georgia Department of Community Health
Georgia Families
Exhibit 2f - WellCare - Non-CHOA Hospital Credentialing Timeliness

Provider Name	Application Date	Credentialing Date	Date CMO Entered Provider into System as Participating	Provider Effective Date as Participating Provider	Number of Days from Application Date to Credentialing Date	Number of Days from Effective Date as Participating Provider to Credentialing Date
THE MEDICAL CENTER	N/A	2/7/2005	6/26/2007	7/1/2007	N/A	0
SUMTER REGIONAL HOSPITAL	N/A	12/4/2001	9/11/2006	9/1/2006	N/A	0

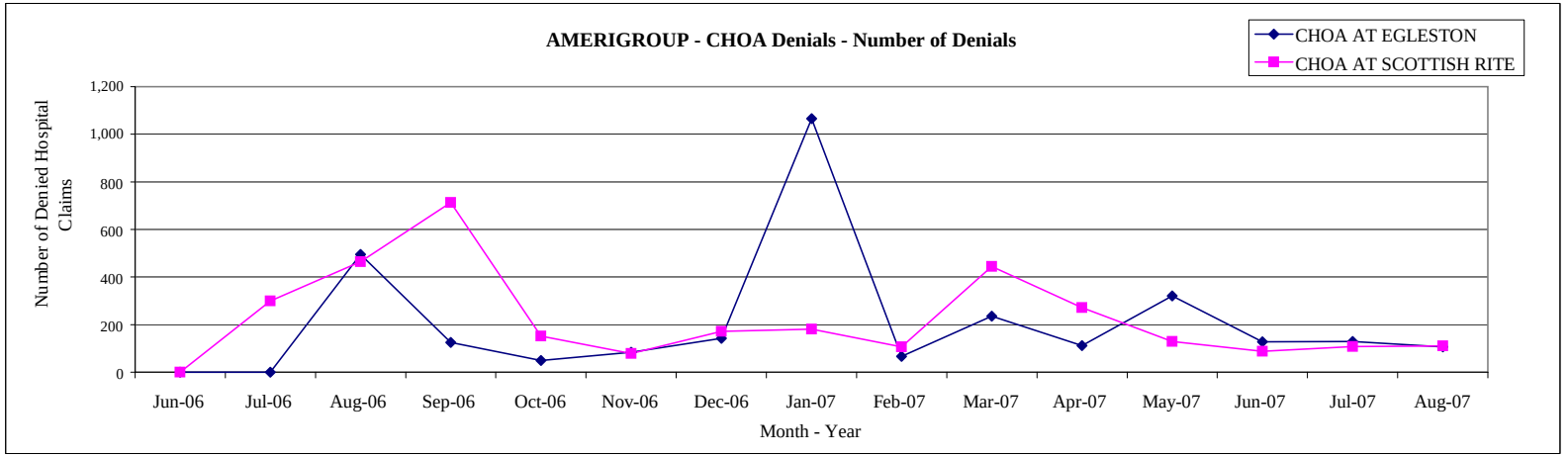
Percentage of facilities credentialed before effective date of In-Network status	87.66%
Percentage of facilities credentialed after effective date of In-Network status	12.34%
Overall average number of days from application date to credentialing date	N/A
Average number of days after effective date to credentialing date	34

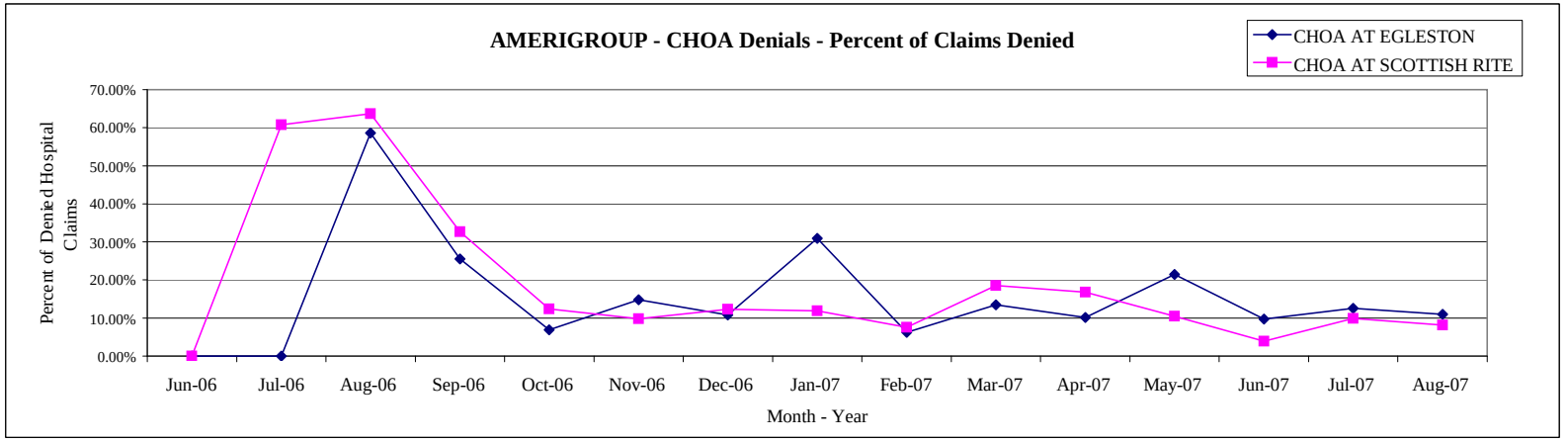
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Dates represent the actual dates provided by the CMOs. See report for comments regarding reliability of data.
Duplicate names may indicate the provider has multiple locations

Georgia Department of Community Health
Georgia Families
Exhibit 3a - AMERIGROUP - Claim Denials for CHOA
June 1, 2006 through August 31, 2007

Provider Name		Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	TOTAL
CHOA AT EGLESTON	**Paid Claims**	0	0	350	365	657	483	1,167	2,380	1,005	1,512	993	1,175	1,187	901	861	13,036
	Denied Claims	0	0	495	125	49	84	142	1,065	67	236	112	321	128	129	106	3,059
	Total Claims	0	0	845	490	706	567	1,309	3,445	1,072	1,748	1,105	1,496	1,315	1,030	967	16,095
	Percent Denied	0.00%	0.00%	58.58%	25.51%	6.94%	14.81%	10.85%	30.91%	6.25%	13.50%	10.14%	21.46%	9.73%	12.52%	10.96%	19.01%
CHOA AT SCOTTISH RITE	**Paid Claims**	0	193	265	1,472	1,075	720	1,223	1,345	1,306	1,948	1,347	1,106	2,181	985	1,245	16,411
	Denied Claims	0	299	464	713	152	78	172	181	107	444	272	129	88	108	110	3,317
	Total Claims	0	492	729	2,185	1,227	798	1,395	1,526	1,413	2,392	1,619	1,235	2,269	1,093	1,355	19,728
	Percent Denied	0.00%	60.77%	63.65%	32.63%	12.39%	9.77%	12.33%	11.86%	7.57%	18.56%	16.80%	10.45%	3.88%	9.88%	8.12%	16.81%

Please note that all figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.





Georgia Department of Community Health
Georgia Families
Exhibit 3a - AMERIGROUP - Summary of Claim Denials for CHOA
June 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Duplicate Submission		**2,614**	**37.37%**
CDD/Y38	Definite Duplicate Claim	2,603	37.22%
346	Duplicate Service	8	0.11%
N53	Dup History Uni or Bilateral Procedure	3	0.04%
Incorrect/Invalid Information		**1,500**	**21.45%**
G41	RV code requires a valid procedure code	1,398	19.99%
G04/G46/G47/G48	Inappropriate billing for this contract	30	0.43%
G24	Non-Compliant CPT/HCPCS code	24	0.34%
G27	Invalid revenue/place of service comb	13	0.19%
G40/G49	Inappropriate Modifier for Service	10	0.14%
Y70/Y71	Description of service required	8	0.11%
G25	Invalid ICD9 Diagnosis Code	4	0.06%
Y66/Y67	Deny - resubmit with a valid code	3	0.04%
N66	History Medical Visit Conflict	3	0.04%
Y92/Y94	Submit medical records for review	2	0.03%
N13	Unlisted/Nonspecific Procedure Code	2	0.03%
Y48	Claim billed under mother's ID	1	0.01%
H86	Invalid principal diagnosis (PDX)	1	0.01%
Y07	Resubmit ER claim w/appropriate ER level	1	0.01%
Time Filing Limit		**1,273**	**18.20%**
TF0	Submitted after plan filing limit	1,273	18.20%
Eligibility Issue		**538**	**7.69%**
ST	Termination	472	6.75%
S23	Date req. Prior to Subscriber Eff Dt.	51	0.73%
376/377/378	Incorrect subscriber ID	13	0.19%
S13	All Enroll events are Future	2	0.03%
Authorization Issue		**450**	**6.43%**
Y40/Y41	Deny preauth not obtained	380	5.43%
UM1	Units exceed UM authorization	40	0.57%
379	Level of care not authorized	16	0.23%
Y29/Y39	Dates of service are outside dates autho	14	0.20%
Miscellaneous		**416**	**5.95%**

Georgia Department of Community Health
Georgia Families
Exhibit 3a - AMERIGROUP - Summary of Claim Denials for CHOA
June 1, 2006 through August 31, 2007

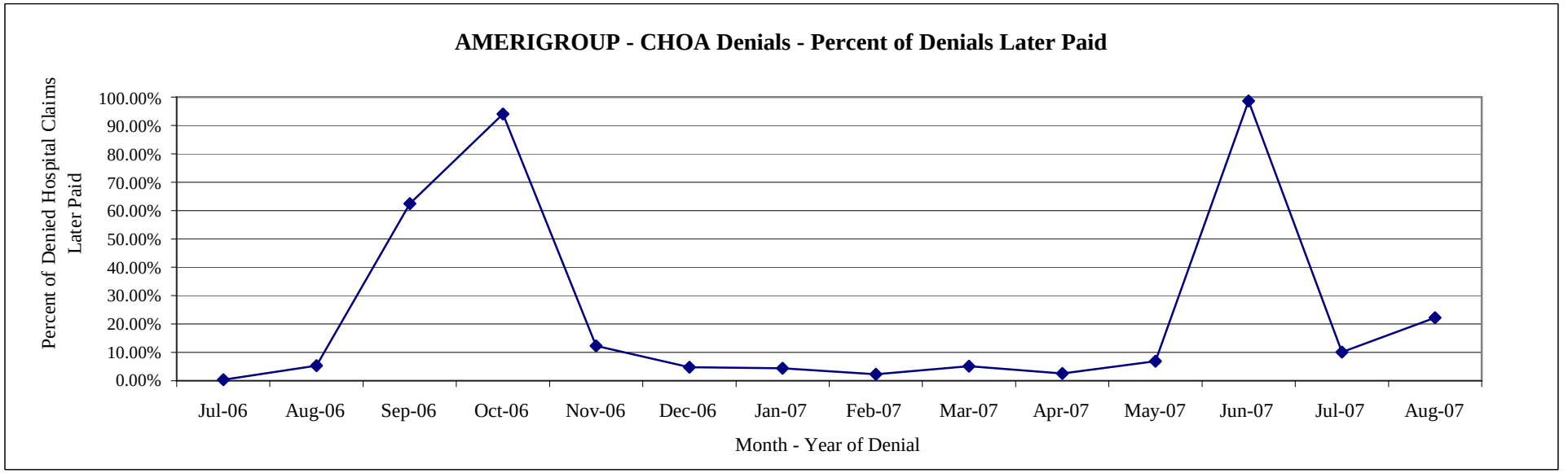
Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
	Not Assigned	307	4.39%
N54/N55	Maximum Allowed Lifetime Occurrence	56	0.80%
383/UMO	Deny per Medical Director	28	0.40%
Y87/Y88	Billing Error	12	0.17%
073	Deny All Claim Lines	10	0.14%
019	Disallowed amount	3	0.04%
Included in Global Payment		**118**	**1.69%**
N59	Incidental due to a procedure in history	51	0.73%
N02	Mutually Exclusive to another procedure	13	0.19%
N01	Incidental to a current procedure	11	0.16%
N58	Mutually Exclusive procedure in history	11	0.16%
N05	Medical visit occurred on same day	10	0.14%
N65	Post-Op within 90 day of surgery in hist	10	0.14%
N51	History Procedure Rebundle	9	0.13%
Y81	Clinic included in physician charges	1	0.01%
N04	Post Op Procedure included in Surgery	1	0.01%
Y50	Service line included in per diem paymen	1	0.01%
Coordination of Benefits Issue		**85**	**1.22%**
CBO/CBP	Primary carrier information required	85	1.22%
Total		**6,994**	

Please note:
- All figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.
- A claim may have more than one denial reason code.
- M&S created 'Reason Groups' to categorize similar types of denials.
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjucidation were not included in the data submitted by the CMO.

Georgia Department of Community Health
Georgia Families
Exhibit 3a - AMERIGROUP - Summary of Claim Denials Later Paid for CHOA - By Month
June 1, 2006 through August 31, 2007

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
July-06	299	1	0.33%	2	0	$0.00
August-06	959	51	5.32%	18	1	$6.09
September-06	838	523	62.41%	47	0	$0.00
October-06	201	189	94.03%	52	1	$0.76
November-06	162	20	12.35%	69	6	$20.45
December-06	314	15	4.78%	70	1	$295.64
January-07	1,246	55	4.41%	61	24	$344.14
February-07	174	4	2.30%	97	2	$103.04
March-07	680	35	5.15%	69	22	$11,233.21
April-07	384	10	2.60%	56	3	$1,422.71
May-07	450	31	6.89%	147	16	$234.31
June-07	216	213	98.61%	230	9	$816.15
July-07	237	24	10.13%	94	17	$1,898.89
August-07	216	48	22.22%	203	3	$12,204.15
Total	**6,376**	**1,219**	**19.12%**	**87 Days**	**105**	**$28,579.54**

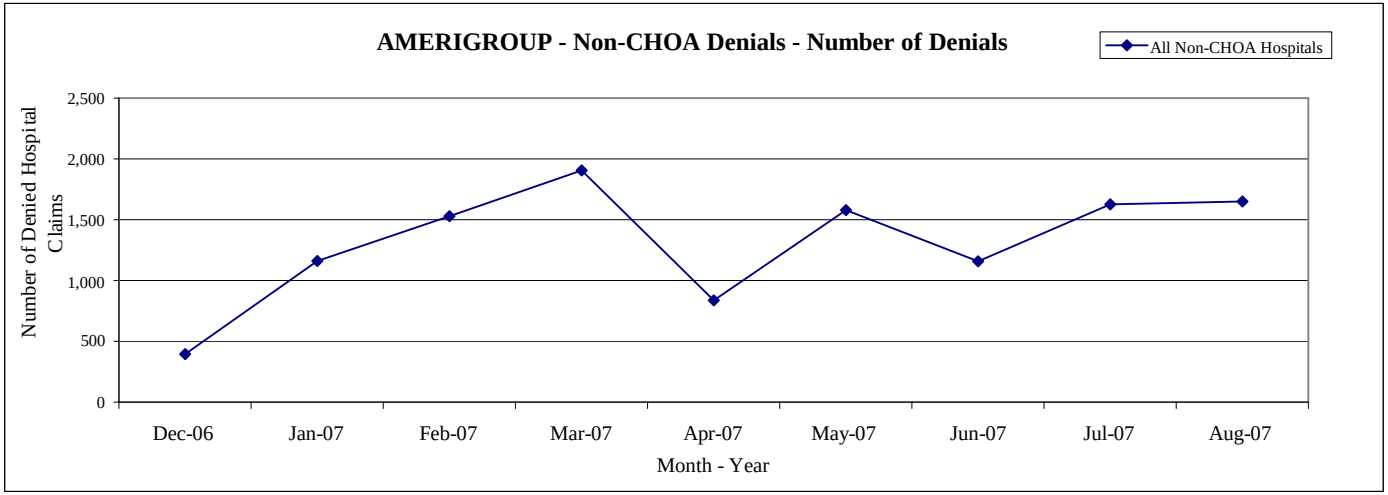
Please note that all figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.

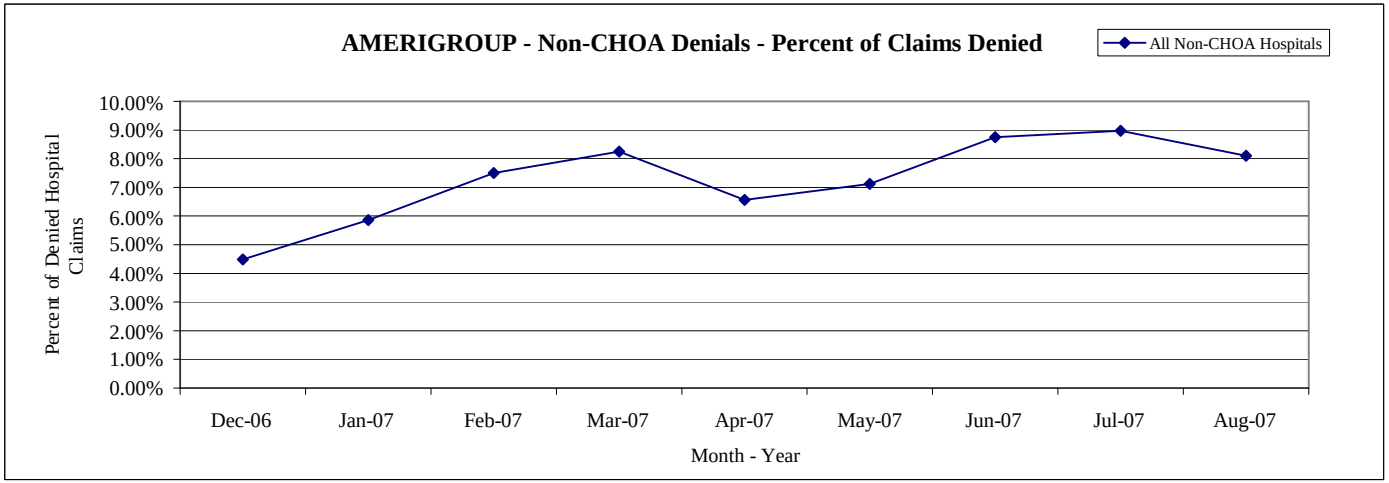


Georgia Department of Community Health
Georgia Families
Exhibit 3b - AMERIGROUP - Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

		Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	TOTAL
All Non-CHOA Hospitals	**Paid Claims**	8,396	18,650	18,844	21,200	11,901	20,618	12,091	16,500	18,706	146,906
	Denied Claims	394	1,160	1,528	1,906	836	1,580	1,159	1,627	1,650	11,840
	Total Claims	8,790	19,810	20,372	23,106	12,737	22,198	13,250	18,127	20,356	158,746
	Percent Denied	4.48%	5.86%	7.50%	8.25%	6.56%	7.12%	8.75%	8.98%	8.11%	7.46%

Please note that all figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.





Georgia Department of Community Health
Georgia Families
Exhibit 3b - AMERIGROUP - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Eligibility Issue		**3,194**	**21.67%**
ST	Termination	3,003	20.38%
S23	Date req. Prior to Subscriber Eff Dt.	135	0.92%
376/377/378	Incorrect subscriber ID	45	0.31%
S13	All Enroll events are Future	11	0.07%
Duplicate Submission		**2,788**	**18.92%**
CDD/Y38	Definite Duplicate Claim	2,726	18.50%
346	Duplicate Service	53	0.36%
N52/N53	Duplicate Uni or Bilateral Procedure	9	0.06%
Authorization Issue		**2,170**	**14.72%**
Y40/Y41	Deny preauth not obtained	1,946	13.20%
379	Level of care not authorized	96	0.65%
Y29/Y39	Dates of service are outside dates autho	46	0.31%
UM1	Units exceed UM authorization	46	0.31%
UM0	Services Disallowed by UM	36	0.24%
Miscellaneous		**1,980**	**13.44%**
	Not Assigned	1,672	11.35%
N54/N55	Maximum Allowed Lifetime Occurrence	182	1.23%
073	Deny All Claim Lines	104	0.71%
PS0	Not a Covered Service	11	0.07%
383	Deny per Medical Director	9	0.06%
B29	Not Covered for GA Medicaid members	1	0.01%
Y49	OON- Included in TMHP roll-up pricing	1	0.01%
Incorrect/Invalid Information		**1,762**	**11.96%**
G41	RV code requires a valid procedure code	902	6.12%
G04/G46/G47/G48	Inappropriate billing for this contract	267	1.81%
Y86/Y87/Y88	Billing Error	159	1.08%
Y12/Y97	Consent form required	104	0.71%
N13	Unlisted/Nonspecific Procedure Code	69	0.47%
G40/G49/G50	Inappropriate Modifier for Service	42	0.28%
G24	Non-Compliant CPT/HCPCS code	41	0.28%
G93	Covered under the professional bill	27	0.18%
Y70/Y71	Description of service required	24	0.16%

Georgia Department of Community Health
Georgia Families
Exhibit 3b - AMERIGROUP - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
N66	History Medical Visit Conflict	19	0.13%
Y92/Y93/Y94	Submit medical records for review	16	0.11%
Y66/Y67	Deny - resubmit with a valid code	12	0.08%
G27	Invalid revenue/place of service comb	9	0.06%
Y48	Claim billed under mother's ID	8	0.05%
Y53/Y55	Inappropriate procedure-modifier comb	6	0.04%
G25	Invalid ICD9 Diagnosis Code	6	0.04%
G23	Invalid ICD9 Procedure Code	5	0.03%
N14	Invalid Gender for Procedure	5	0.03%
H86	Invalid principal diagnosis (PDX)	5	0.03%
384/386	Please resubmit claim with TPI number	4	0.03%
G09	Incorrect Tax ID#	4	0.03%
G69	Invalid Patient Status/Discharge Code	3	0.02%
H88	Conflicting birthweight	3	0.02%
S2	Date requested < Subscriber's Birth Date	3	0.02%
Y58/Y60	Rebill with appropriate surgical CPT	3	0.02%
G84	Resubmit with valid Proc/Rev code	2	0.01%
H84	Invalid discharge status	2	0.01%
H89	Non-specific birthweight	2	0.01%
N15	Age exceeds normal range for procedure	2	0.01%
G53	Location not appropriate for procedure	1	0.01%
G60	Incorrect billing form/provider	1	0.01%
N79	Units do not match submitted date range.	1	0.01%
S1C	Plan not effective on date requested	1	0.01%
Y85	Resubmit with itemized bill	1	0.01%
Y91	Submit mother's claims - nb chrgs incl	1	0.01%
Y68	Time units in total minutes needed	1	0.01%
Y72	Resubmit ER claim w/appropriate ER level	1	0.01%
Included in Global Payment		**1,378**	**9.35%**
INC/IND	Included in per diem/case rate	416	2.82%
N01	Incidental to a current procedure	335	2.27%
N59	Incidental due to a procedure in history	301	2.04%
N05	Medical visit occurred on same day	101	0.69%

Georgia Department of Community Health
Georgia Families
Exhibit 3b - AMERIGROUP - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

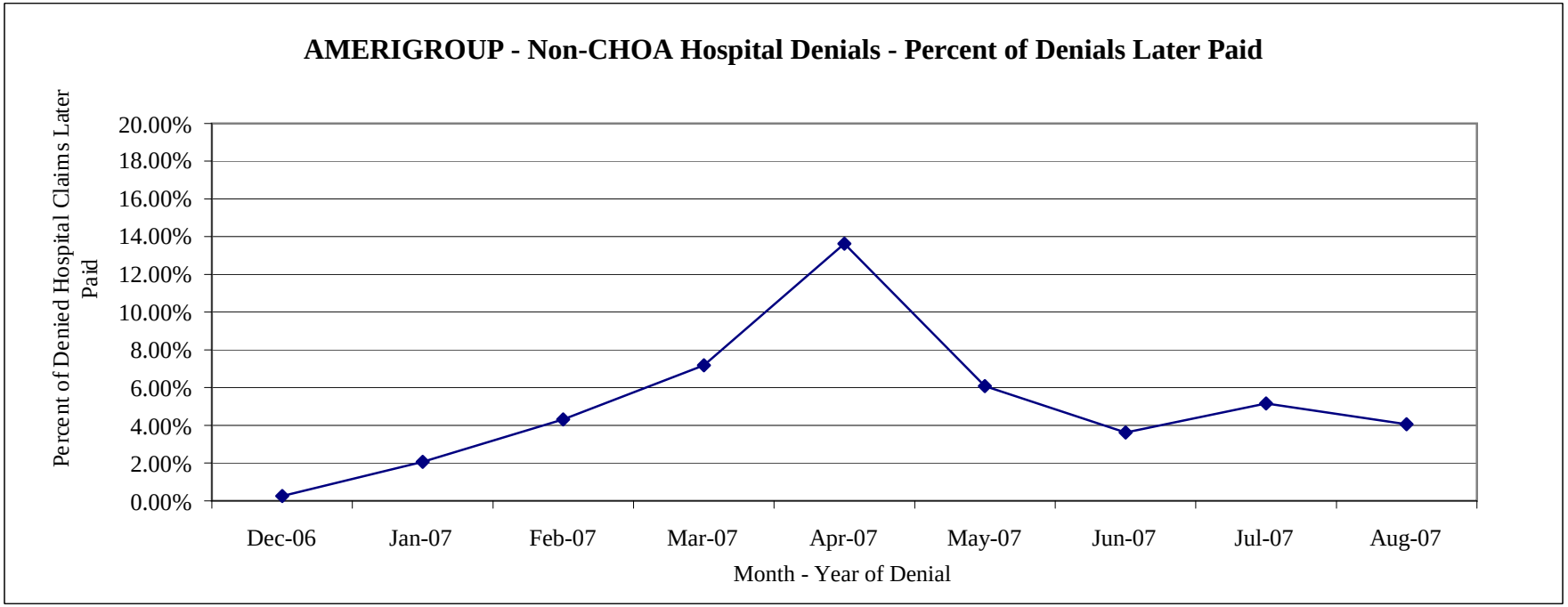
Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
N02	Mutually Exclusive to another procedure	66	0.45%
N58	Mutually Exclusive procedure in history	64	0.43%
N65	Post-Op within 90 day of surgery in hist	27	0.18%
Y50	Service line included in per diem paymen	27	0.18%
Y81/Y82	Clinic included in physician charges	25	0.17%
N51	History Procedure Rebundle	8	0.05%
H81	Record doesn't meet criteria for any DRG	3	0.02%
N04	Post Op Procedure included in Surgery	3	0.02%
G38	Service included in higher level of care	2	0.01%
Time Filing Limit		**961**	**6.52%**
TF0	Submitted after plan filing limit	777	5.27%
TF1	Submitted After Provider's Filing Limit	184	1.25%
Coordination of Benefits Issue		**504**	**3.42%**
CBO/CBP	Primary carrier information required	504	3.42%
Total		**14,737**	

Please note:
- All figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.
- A claim may have more than one denial reason code.
- M&S created 'Reason Groups' to categorize similar types of denials.
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjucidation were not included in the data submitted by the CMO.

Georgia Department of Community Health
Georgia Families
Exhibit 3b - AMERIGROUP - Summary of Claim Denials Later Paid for Non-CHOA Hospitals - By Month
December 1, 2006 through August 31, 2007

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
December-06	394	1	0.25%	4	0	$0.00
January-07	1,160	24	2.07%	24	0	$0.00
February-07	1,528	66	4.32%	27	15	$242.72
March-07	1,906	137	7.19%	36	7	$110.94
April-07	836	114	13.64%	58	32	$117.50
May-07	1,580	96	6.08%	60	15	$564.32
June-07	1,159	42	3.62%	74	20	$1,408.17
July-07	1,627	84	5.16%	64	28	$2,809.40
August-07	1,650	67	4.06%	38	6	$2,106.86
Total	**11,840**	**631**	**5.33%**	**43 Days**	**123**	**$7,359.91**

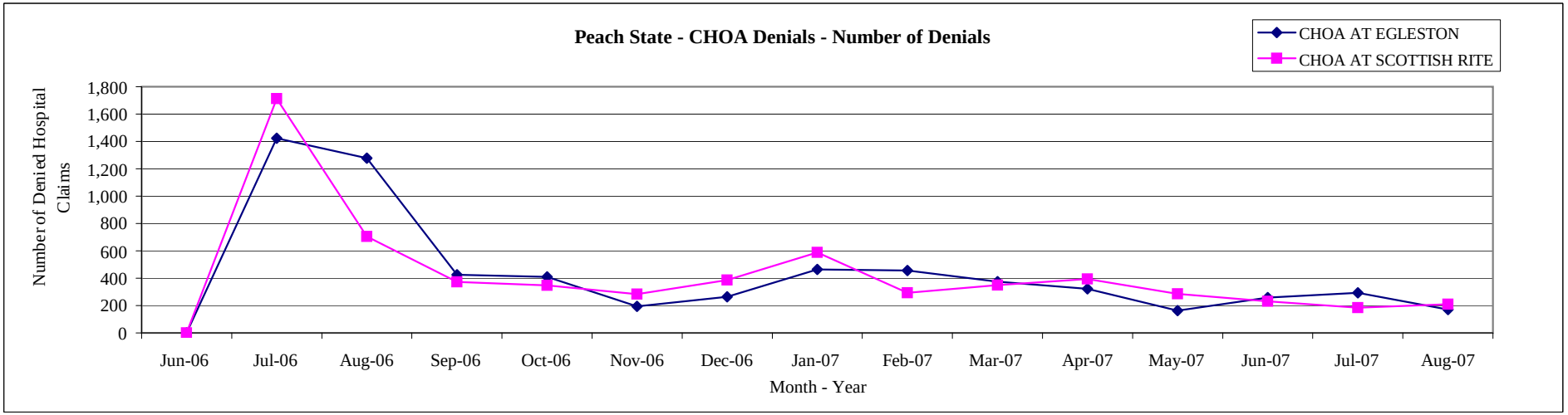
Please note that all figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.

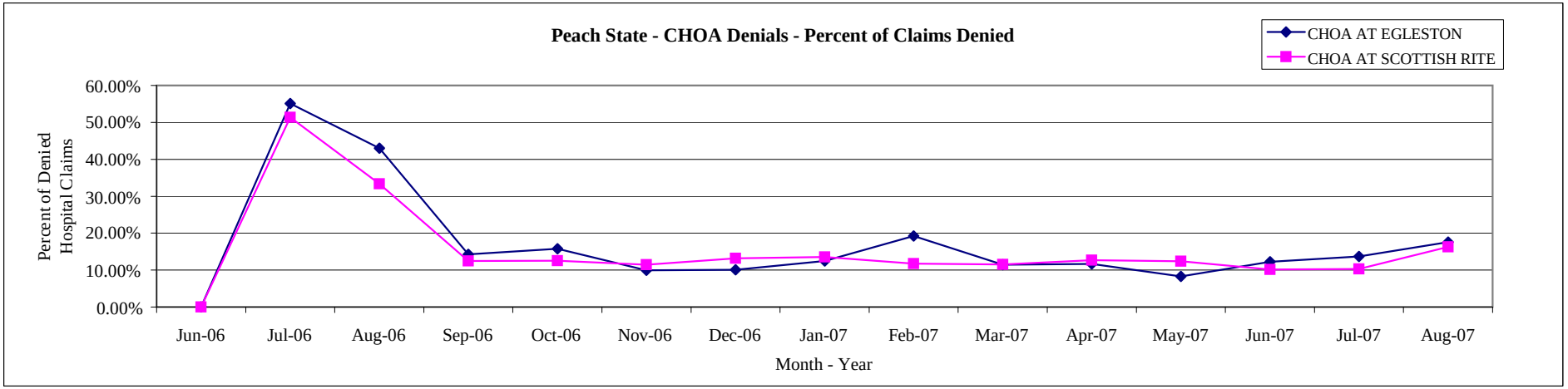


Georgia Department of Community Health
Georgia Families
Exhibit 3c - Peach State Health Plan - Claim Denials for CHOA
June 1, 2006 through August 31, 2007

Provider Name		Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	TOTAL
CHOA AT EGLESTON	**Paid Claims**	0	1,160	1,693	2,560	2,189	1,763	2,360	3,260	1,920	2,894	2,442	1,816	1,853	1,852	803	28,565
	Denied Claims	0	1,424	1,277	425	409	195	264	464	457	375	322	164	259	293	171	6,499
	Total Claims	0	2,584	2,970	2,985	2,598	1,958	2,624	3,724	2,377	3,269	2,764	1,980	2,112	2,145	974	35,064
	Percent Denied	0.00%	55.11%	43.00%	14.24%	15.74%	9.96%	10.06%	12.46%	19.23%	11.47%	11.65%	8.28%	12.26%	13.66%	17.56%	18.53%
CHOA AT SCOTTISH RITE	**Paid Claims**	0	1,622	1,405	2,614	2,427	2,203	2,546	3,747	2,207	2,683	2,713	2,018	2,059	1,608	1,074	30,926
	Denied Claims	0	1,712	704	372	348	284	387	588	293	349	394	285	232	184	209	6,341
	Total Claims	0	3,334	2,109	2,986	2,775	2,487	2,933	4,335	2,500	3,032	3,107	2,303	2,291	1,792	1,283	37,267
	Percent Denied	0.00%	51.35%	33.38%	12.46%	12.54%	11.42%	13.19%	13.56%	11.72%	11.51%	12.68%	12.38%	10.13%	10.27%	16.29%	17.02%

Please note that all figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.





Georgia Department of Community Health
Georgia Families
Exhibit 3c - Peach State Health Plan - Summary of Claim Denials for CHOA
June 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Incorrect, Incomplete or Invalid Information		**5,462**	**38.99%**
EX16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED	3,359	23.98%
EXN3	YOUR NPI IS NOT ON FILE/VALID OR YOU HAVE NOT BILLED WITH YOUR NPI	1,109	7.92%
EX09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE	113	0.81%
EX99	DENY:MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT	110	0.79%
EXLY	DENY: PLEASE RESUBMIT WITH INVOICE FOR PAYMENT	96	0.69%
EXU1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS	91	0.65%
EXEC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT	90	0.64%
EXMQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT	89	0.64%
EXVC	DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES	58	0.41%
EXIV	DENY: INVALID/DELETED/MISSING CPT CODE	51	0.36%
EXSQ	DENY: NOT REIMBURSEABLE TO THIS PROVIDER - BILL DIALYSIS CENTER	47	0.34%
EXGM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K	43	0.31%
EXGA	DENY: PROCEDURE NOT COVERED FOR THE MEMBER'S AGE	34	0.24%
EXBG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT	30	0.21%
EX0A	DENY: NOT REIMBURSABLE - BILL UNDER AMBULANCE MEDICAID ID	28	0.20%
EX92	PAID ACCORDING TO CONTRACT / STATE PROCESSING GUIDELINES	21	0.15%
EXDW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT	10	0.07%
EXRD	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.	9	0.06%
EX9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS	8	0.06%
EX6L	EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL	7	0.05%
EXMF	DENY: INAPPROPRIATE MEDICAID# SUBMITTED FOR SVC PROVIDER,PLEASE RESUBMIT	6	0.04%
EX57	DENY: CODE WAS DENIED BY CODE AUDITING SOFTWARE	6	0.04%
EX07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX	5	0.04%
EX10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX	5	0.04%
EX3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT	5	0.04%
EXLO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.	5	0.04%
EXDJ	DENY:INAPPROPRIATE CODE BILLED,CORRECT & RESUBMIT	4	0.03%
EXUZ	DENY: SERVICES BILLED ON INCORRECT FORM, PLEASE REBILL ON A UB92	4	0.03%
EX58	DENY: CODE REPLACED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION	4	0.03%
EXND	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE	3	0.02%
EX4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT	2	0.01%
EXBI	DENY: CLAIM CANNOT BE PROCESSED WITHOUT AN ITEMIZED BILL	2	0.01%
EXD4	PAY: PER STATE GUIDELINES - PROCEDURE NOT SEPARATELY REIMBURSABLE	2	0.01%
EX17	DENY: REQUESTED INFORMATION WAS NOT PROVIDED	1	0.01%
EXGB	DENY: GLOBAL CODE IS INVALID PER STATE GUIDELINES	1	0.01%
EXRJ	DENY: REVENUE CODES NOT BILLED ON THE UB92, PLEASE RE-SUBMIT	1	0.01%
EXMG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT	1	0.01%

Georgia Department of Community Health
Georgia Families
Exhibit 3c - Peach State Health Plan - Summary of Claim Denials for CHOA
June 1, 2006 through August 31, 2007

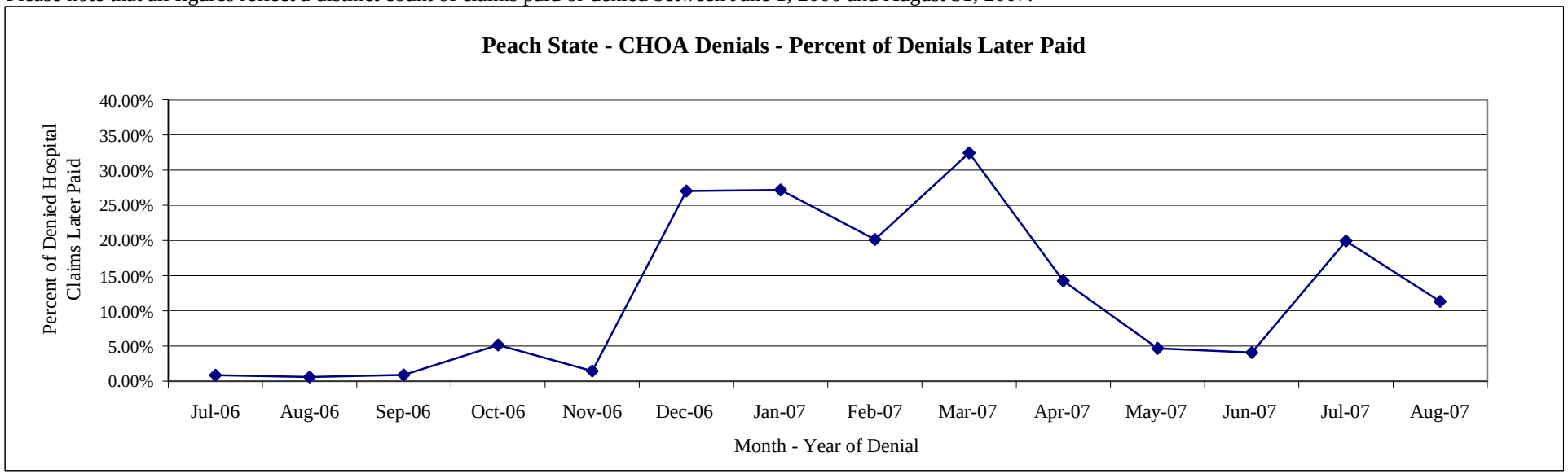
Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
EXN5	DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM	1	0.01%
EX9N	CLAIM CANNOT BE PROCESSED WITHOUT OPERATIVE REPORT	1	0.01%
Duplicate Submission		**4,297**	**30.67%**
EX18	DENY: DUPLICATE CLAIM/SERVICE	4,159	29.69%
EXDS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS	138	0.99%
Authorization Issue		**1,423**	**10.16%**
EXA1	DENY: AUTHORIZATION NOT ON FILE	1,032	7.37%
EXDZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	208	1.48%
EXHP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING	100	0.71%
EXHS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	39	0.28%
EXHL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH	37	0.26%
EXHT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	7	0.05%
Eligibility Issue		**1,251**	**8.93%**
EX28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED	1,241	8.86%
EXMA	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT	9	0.06%
EX26	DENY: EXPENSES INCURRED PRIOR TO COVERAGE	1	0.01%
Benefit Issue		**669**	**4.78%**
EX47	DENY: THIS DIAGNOSIS IS NOT COVERED	329	2.35%
EX46	DENY: THIS SERVICE IS NOT COVERED	269	1.92%
EXEB	DENY: DENIED BY MEDICAL SERVICES	46	0.33%
EX35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED	23	0.16%
EXZW	AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS	2	0.01%
Time Filing Limit		**530**	**3.78%**
EX29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED	530	3.78%
Coordination of Benefits Issue		**297**	**2.12%**
EXL6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.	295	2.11%
EXI1	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT	2	0.01%
Claim Submission Error		**80**	**0.57%**
EXMH	DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING	53	0.38%
EXVS	DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.	14	0.10%
EXRX	DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.	13	0.09%
Total		**14,009**	

Please note:
- All figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.
- A claim may have more than one denial reason code.
- M&S created 'Reason Groups' to categorize similar types of denials.
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjucidation were not included in the data submitted by the CMO.

Georgia Department of Community Health
Georgia Families
Exhibit 3c - Peach State Health Plan - Summary of Claim Denials Later Paid for CHOA - By Month
June 1, 2006 through August 31, 2007

Month	Number of Denials	Number of Denials Overturned	Percentage Overturned	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
July-06	3,136	27	0.86%	9	0	$0.00
August-06	1,981	12	0.61%	15	0	$0.00
September-06	797	7	0.88%	21	1	$182.92
October-06	757	39	5.15%	50	1	$99.55
November-06	479	7	1.46%	38	3	$940.56
December-06	651	176	27.04%	128	93	$3,548.13
January-07	1,052	286	27.19%	116	164	$7,247.11
February-07	750	151	20.13%	118	80	$18,155.62
March-07	724	235	32.46%	125	51	$7,310.65
April-07	716	102	14.25%	97	55	$9,813.77
May-07	449	21	4.68%	80	12	$6,097.20
June-07	491	20	4.07%	99	14	$4,227.76
July-07	477	95	19.92%	187	60	$2,331.74
August-07	380	43	11.32%	90	26	$8,609.96
Total	**12,840**	**1,221**	**9.51%**	**84 Days**	**560**	**$68,564.97**

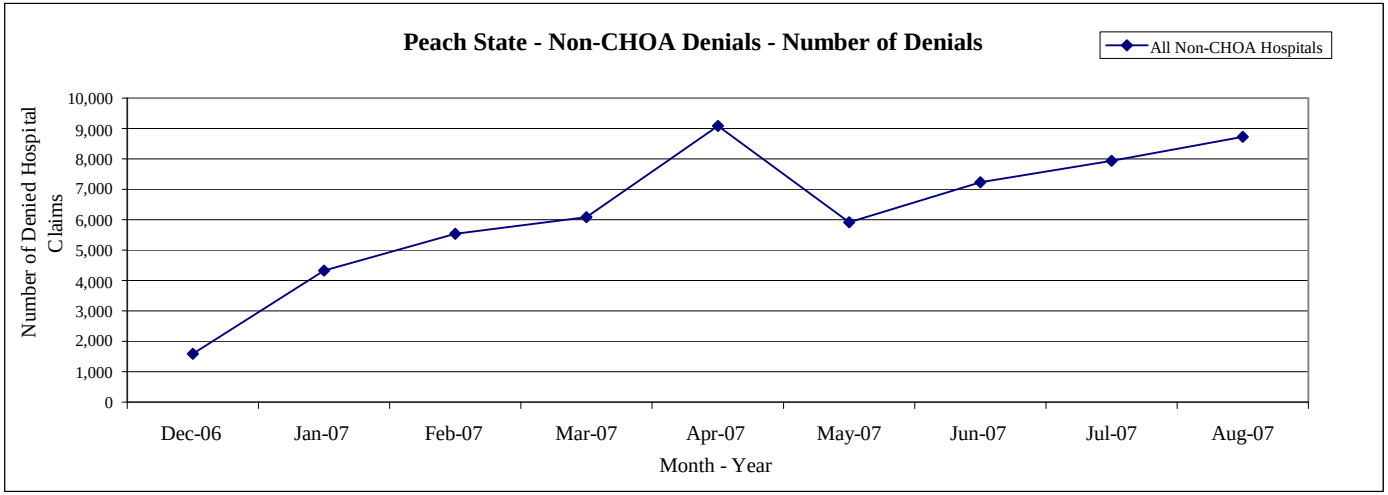
Please note that all figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.

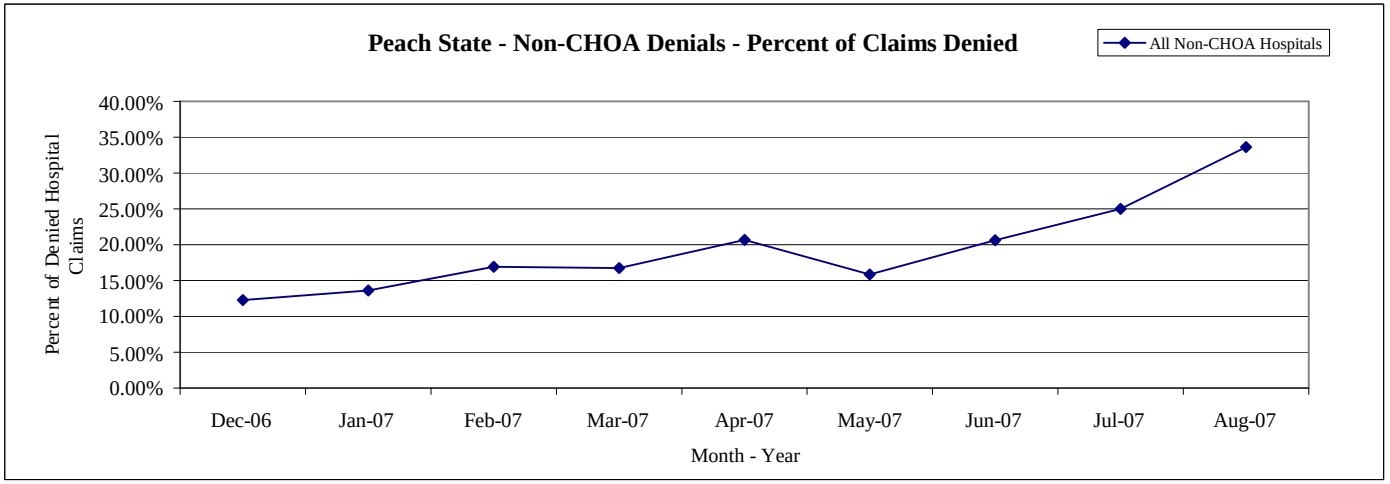


Georgia Department of Community Health
Georgia Families
Exhibit 3d - Peach State Health Plan - Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

		Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	TOTAL
All Non-CHOA Hospitals	**Paid Claims**	11,334	27,479	27,144	30,286	34,866	31,446	27,872	23,799	17,236	231,462
	Denied Claims	1,586	4,324	5,534	6,082	9,088	5,914	7,236	7,935	8,729	56,428
	Total Claims	12,920	31,803	32,678	36,368	43,954	37,360	35,108	31,734	25,965	287,890
	Percent Denied	12.28%	13.60%	16.93%	16.72%	20.68%	15.83%	20.61%	25.00%	33.62%	19.60%

Please note that all figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.





Georgia Department of Community Health
Georgia Families
Exhibit 3d - Peach State Health Plan - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Incorrect, Incomplete or Invalid Information		**26,296**	**36.05%**
EXN3	YOUR NPI IS NOT ON FILE/VALID OR YOU HAVE NOT BILLED WITH YOUR NPI	11,702	16.04%
EX16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED	4,060	5.57%
EXBG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT	2,757	3.78%
EXEC	DIAGNOSIS CANNOT BE USED AS PRIMARY DIAGNOSIS, PLEASE RESUBMIT	1,421	1.95%
EX99	DENY:MISC/UNLISTED CODES CAN NOT BE PROCESSED W/O DESCRIPTION/REPORT	930	1.28%
EXGM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K	700	0.96%
EX9M	DENY: THIS CPT CODE IS INVALID WHEN BILLED WITH THIS DIAGNOSIS	592	0.81%
EXVC	DENY - PLEASE RESUBMIT ACCORDING TO VACCINES FOR CHILDREN GUIDELINES	517	0.71%
EXMQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT	480	0.66%
EX09	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S AGE	393	0.54%
EXHQ	DENY: EDI CLAIM MUST BE SUBMITTED IN HARD COPY W/CONSENT FORM ATTACHED	367	0.50%
EX0A	DENY: NOT REIMBURSABLE - BILL UNDER AMBULANCE MEDICAID ID	336	0.46%
EXLO	DENY: CPT & LOCATION ARE NOT COMPATIBLE, PLEASE RESUBMIT.	237	0.32%
EXGA	DENY: PROCEDURE NOT COVERED FOR THE MEMBER'S AGE	198	0.27%
EX07	DENY: THE PROCEDURE CODE IS INCONSISTENT WITH THE PATIENT'S SEX	186	0.26%
EXND	DENY: THIS IS A DELETED CODE AT THE TIME OF SERVICE	162	0.22%
EX10	DENY: THE DIAGNOSIS IS INCONSISTENT WITH THE PATIENT'S SEX	138	0.19%
EXIV	DENY: INVALID/DELETED/MISSING CPT CODE	133	0.18%
EXRD	DENY: REVENUE CODE AND DIAGNOSIS ARE NOT COMPATIBLE. PLEASE RESUBMIT.	120	0.16%
EXU1	CLAIM CANNOT BE PROCESSED WITHOUT MEDICAL RECORDS	110	0.15%
EXMF	DENY: INAPPROPRIATE MEDICAID# SUBMITTED FOR SVC PROVIDER,PLEASE RESUBMIT	108	0.15%
EXRM	DENY: MODIFIER REQUIRED FOR PAYMENT OF SERVICE - RESUBMIT W/MODIFIER	106	0.15%
EXNV	DENY: REQUIRED FORM/STATEMENT FOR SERVICE NOT VALID/MISSING INFORMATIONN	62	0.09%
EXDJ	DENY:INAPPROPRIATE CODE BILLED,CORRECT & RESUBMIT	61	0.08%
EX9I	INFORMATION REQUESTED WAS NOT RECEIVED WITHIN THE TIME FRAME SPECIFIED	49	0.07%
EXDD	DENY:REQUIRED FORM/STATEMENT FOR SERVICE NOT RECEIVED	43	0.06%
EXIM	DENY: RESUBMIT WITH MODIFIER SPECIFIED BY STATE FOR PROPER PAYMENT	42	0.06%
EXSQ	DENY: NOT REIMBURSEABLE TO THIS PROVIDER - BILL DIALYSIS CENTER	42	0.06%
EXN5	DENY: NAME OF DRUG, NDC NUMBER AND QUANTITY IS REQUIRED TO PROCESS CLAIM	40	0.05%
EXDX	DIAGNOSIS BILLED IS INVALID, PLEASE RESUBMIT WITH CORRECT CODE.	37	0.05%
EX4D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 5TH DIGIT PLEASE RESUBMIT	34	0.05%
EX3D	DENY: NON-SPECIFIC DIAGNOSIS- REQUIRES 4TH DIGIT PLEASE RESUBMIT	30	0.04%
EXLY	DENY: PLEASE RESUBMIT WITH INVOICE FOR PAYMENT	28	0.04%
EXMG	DENY: SIGNATURE MISSING FROM BOX 31, PLEASE RESUBMIT	28	0.04%
EXNX	DENY: INVALID OR NO TAX ID NUMBER SUBMITTED ON CLAIM, PLEASE RESUBMIT	11	0.02%

Georgia Department of Community Health
Georgia Families
Exhibit 3d - Peach State Health Plan - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
EX86	DENY: THIS IS NOT A VALID MODIFIER FOR THIS CODE	8	0.01%
EX17	DENY: REQUESTED INFORMATION WAS NOT PROVIDED	7	0.01%
EXDW	DENY: INAPPROPRIATE DIAGNOSIS BILLED, CORRECT AND RESUBMIT	6	0.01%
EXRC	DENY: REQUIRED REFERRAL CODE FOR HEALTH CHECK VISIT INVALID OR MISSING	5	0.01%
EXI4	DENY: ICD-9 PROCEDURE CODE REQUIRES A 4TH DIGIT	2	0.00%
EXTF	DENY: CPT/HCPCS CODES NOT ACCEPTABLE FOR SERVICE DATES PRIOR TO NEW YEAR	2	0.00%
EX0C	1999 CODE DELETED IN 2000, PLEASE REBILL WITH CORRECT CODE	1	0.00%
EX9N	CLAIM CANNOT BE PROCESSED WITHOUT OPERATIVE REPORT	1	0.00%
EXI3	DENY: ICD-9 PROCEDURE CODE REQUIRES A 3RD DIGIT	1	0.00%
EXOX	DENY: CODE IS CONSIDERED AN INTEGRAL COMPONENT OF THE E/M CODE BILLED	1	0.00%
EXSR	SUBMIT ER RECORDS & EOP W/IN 45 DAYS FOR PRESENTING SYMPTOM ASSESSMENT	1	0.00%
EXMO	MODIFIER BILLED IS NOT VALID, PLEASE RESUBMIT WITH CORRECT CODE.	1	0.00%
Duplicate Submission		**22,283**	**30.55%**
EX18	DENY: DUPLICATE CLAIM/SERVICE	21,294	29.19%
EXDS	DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS	989	1.36%
Non Covered Procedure		**6,164**	**8.45%**
EX46	DENY: THIS SERVICE IS NOT COVERED	5,492	7.53%
EX0R	DENY: SERVICE NOT ON HMO RADIOLOGY SCHEDULE-INELIGIBLE FOR REIMBURSEMENT	271	0.37%
EXEB	DENY: DENIED BY MEDICAL SERVICES	225	0.31%
EXNT	DENY:PROVIDER NOT CONTRACTED FOR THIS SERVICE-DO NOT BILL PATIENT	63	0.09%
EXZW	AFTER REVIEW, PREV DECISION UPHELD, SEE PROV HANDBOOK FOR APPEAL PROCESS	26	0.04%
EX57	DENY: CODE WAS DENIED BY CODE AUDITING SOFTWARE	25	0.03%
EX35	DENY: BENEFIT MAXIMUM HAS BEEN REACHED	18	0.02%
EX58	DENY: CODE REPLACED BASED ON CODE AUDITING SOFTWARE RECOMMENDATION	11	0.02%
EX47	DENY: THIS DIAGNOSIS IS NOT COVERED	11	0.02%
EXNA	OTHER INS. DENIED - OOP PROVIDER/NOT AUTHORIZED - SERVICES NOT PAYABLE	7	0.01%
EX40	DENY: CHARGES DO NOT MEET QUALIFICATIONS FOR EMERGENCY CARE OUT OF AREA	6	0.01%
EX50	DENY:NOT A MCO COVERED BENEFIT	4	0.01%
EXBO	DENY:NOT PAYABLE-ANOTHER PROIVDER/FACILTY BILLED FOR COMPLETE SERVICE	2	0.00%
EXV1	DENY: SERVICE IS INCLUDED IN THE DELIVERY PAYMENT	1	0.00%
EXZC	DENY: PROCEDURE IS INAPPROPRIATE FOR PROVIDER SPECIALTY	1	0.00%
EXBD	DENY: BENEFIT IS NOT COVERED BY HMO	1	0.00%
Eligibility Issue		**6,022**	**8.26%**
EX28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED	5607	7.69%
EXMA	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT	414	0.57%
EX26	DENY: EXPENSES INCURRED PRIOR TO COVERAGE	1	0.00%

Georgia Department of Community Health
Georgia Families
Exhibit 3d - Peach State Health Plan - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials
Time Filing Limit		**5,100**	**6.99%**
EX29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED	5,054	6.93%
EXQR	DENY: ADJUSTMENT WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT	39	0.05%
EXRQ	DENY: ORIGINAL SUBMISSION WAS NOT RECEIVED WITHIN TIMELY FILING LIMIT	7	0.01%
Authorization Issue		**4,217**	**5.78%**
EXA1	DENY: AUTHORIZATION NOT ON FILE	3,316	4.55%
EXHP	DENY: CLAIM AND AUTH SERVICE PROVIDER NOT MATCHING	398	0.55%
EXHS	DENY: CLAIM AND AUTH PROVIDER SPECIALTY NOT MATCHING	211	0.29%
EXDZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	177	0.24%
EXHL	DENY: CLAIM AND AUTH LOCATIONS DO NOT MATCH	90	0.12%
EXHT	DENY: CLAIM AND AUTH TREATMENT TYPE NOT MATCHING	25	0.03%
Coordination of Benefits Issue		**1,877**	**2.57%**
EXL6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.	1,747	2.40%
EXI1	OTHER INSURANCE EOB SUBMITTED DOES NOT MATCH BILLED, PLEASE RESUBMIT	78	0.11%
EX6L	EOB INCOMPLETE-PLEASE RESUBMIT WITH REASON OF OTHER INSURANCE DENIAL	27	0.04%
EXLR	DENY:WHEN PRIME INS.RECIEVES INFO-RESUBMIT TO SECONDARY INS.	25	0.03%
Claim Submission Error		**980**	**1.34%**
EXMH	DENY: PLEASE SUBMIT TO MENTAL HEALTH PLAN FOR PROCESSING	376	0.52%
EXDT	DENY: PLEASE FORWARD TO THE DENTAL VENDOR FOR PROCESSING.	215	0.29%
EXVS	DENY: PLEASE SUBMIT TO THE VISION VENDOR FOR PROCESSING.	202	0.28%
EXRX	DENY: PLEASE SUBMIT TO THE PHARMACY VENDOR FOR PROCESSING.	187	0.26%
Total		**72,939**	

Please note:
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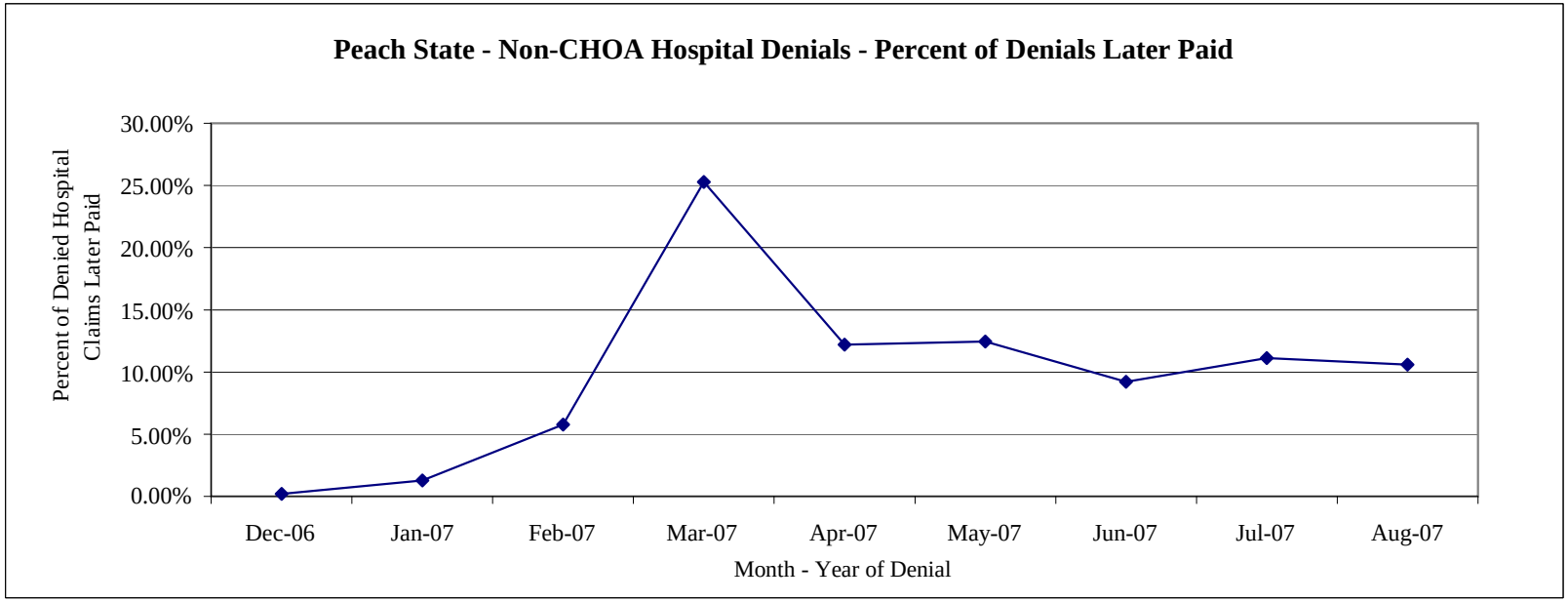
- A claim may have more than one denial reason code.
- M&S created 'Reason Groups' to categorize similar types of denials.
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjucidation were not included in the data submitted by the CMO.

Georgia Department of Community Health
Georgia Families
Exhibit 3d - Peach State Health Plan - Summary of Claim Denials Later Paid for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Month	Number of Denials	Number of Denials Overturned	Percentage Overturned	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
December-06	1,586	3	0.19%	4	0	$0.00
January-07	4,324	55	1.27%	16	14	$17.98
February-07	5,534	320	5.78%	39	32	$207.50
March-07	6,082	1,537	25.27%	33	113	$2,336.13
April-07	9,088	1,109	12.20%	80	214	$11,229.37
May-07	5,914	736	12.45%	75	280	$15,008.49
June-07	7,236	666	9.20%	64	364	$33,478.88
July-07	7,935	882	11.12%	71	258	$21,980.81
August-07	8,729	925	10.60%	99	364	$34,170.42
Total	**56,428**	**6,233**	**11.05%**	**53 Days**	**1,639**	**$118,429.58**

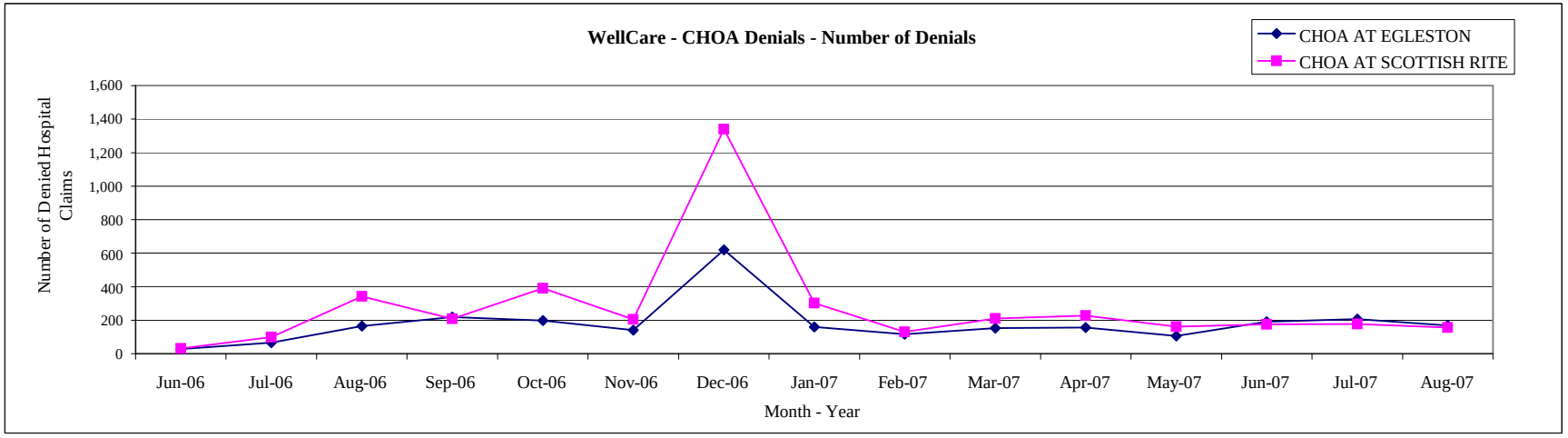
Please note that all figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.

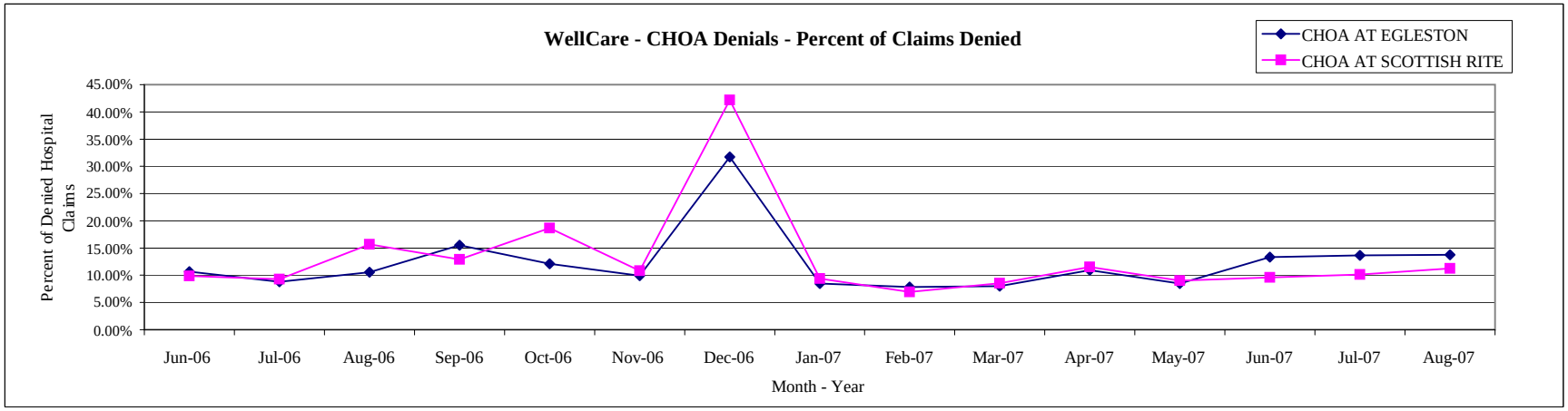


Georgia Department of Community Health
Georgia Families
Exhibit 3e - WellCare - Claim Denials for CHOA
June 1, 2006 through August 31, 2007

Provider Name		Jun-06	Jul-06	Aug-06	Sep-06	Oct-06	Nov-06	Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	TOTAL
CHOA AT EGLESTON	**Paid Claims**	234	686	1,390	1,187	1,435	1,281	1,333	1,718	1,369	1,747	1,272	1,135	1,240	1,312	1,059	18,398
	Denied Claims	28	66	164	218	198	141	619	159	116	152	156	105	191	207	169	2,689
	Total Claims	262	752	1,554	1,405	1,633	1,422	1,952	1,877	1,485	1,899	1,428	1,240	1,431	1,519	1,228	21,087
	Percent Denied	10.69%	8.78%	10.55%	15.52%	12.12%	9.92%	31.71%	8.47%	7.81%	8.00%	10.92%	8.47%	13.35%	13.63%	13.76%	12.75%
CHOA AT SCOTTISH RITE	**Paid Claims**	284	966	1,838	1,405	1,705	1,682	1,837	2,915	1,754	2,248	1,741	1,622	1,661	1,571	1,238	24,467
	Denied Claims	31	99	341	208	391	204	1,340	302	131	210	227	161	176	177	157	4,155
	Total Claims	315	1,065	2,179	1,613	2,096	1,886	3,177	3,217	1,885	2,458	1,968	1,783	1,837	1,748	1,395	28,622
	Percent Denied	9.84%	9.30%	15.65%	12.90%	18.65%	10.82%	42.18%	9.39%	6.95%	8.54%	11.53%	9.03%	9.58%	10.13%	11.25%	14.52%

Please note that all figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.





Georgia Department of Community Health
Georgia Families
Exhibit 3e - WellCare - Summary of Claim Denials for CHOA
June 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials	Internal EOB
Authorization Issue		**2,813**	**30.35%**	
197	Precertification/authorization/notification absent.	2,407	25.97%	
39	Services denied at the time authorization/pre-certification was requested.	175	1.89%	
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	129	1.39%	
198	Payment Adjusted for exceeding precertification/ authorization.	102	1.10%	
Duplicate Submission		**2,428**	**26.19%**	
18	Duplicate claim/service.	2,307	24.89%	
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	96	1.04%	
PODUP	POTENTIAL DUPLICATE	25	0.27%	YES
Incorrect/Invalid Information		**1,633**	**17.62%**	
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	1,061	11.45%	
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	391	4.22%	
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	146	1.58%	
5	The procedure code/bill type is inconsistent with the place of service.	24	0.26%	
181	Payment adjusted because this procedure code was invalid on the date of service	6	0.06%	
RV105	PROVIDER BILLING ERROR	4	0.04%	YES
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes	1	0.01%	
Fee, Service Limit, or Charge Issue		**1,511**	**16.30%**	
94	Processed in Excess of charges.	773	8.34%	
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	410	4.42%	
204	This service/equipment/drug is not covered under the patients current benefit plan	286	3.09%	
A1	Claim denied charges	28	0.30%	
96	Non-covered charge(s).	12	0.13%	
WCPNP	WHOLE CLAIM PRICE - NO PRICING	2	0.02%	YES

Georgia Department of Community Health
Georgia Families
Exhibit 3e - WellCare - Summary of Claim Denials for CHOA
June 1, 2006 through August 31, 2007

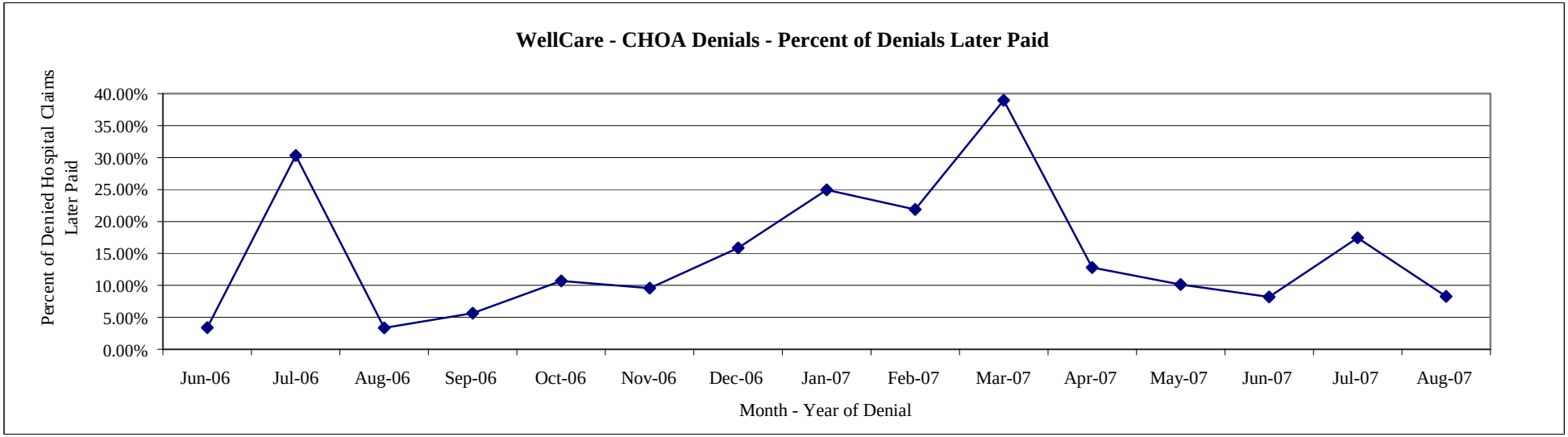
Reason Code / Group	Reason Description	Claim Count	Percent of All Denials	Internal EOB
Claim Submission Error		**378**	**4.08%**	
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	377	4.07%	
DORAL	PLEASE SUBMIT CLAIM TO DORAL DENTAL	1	0.01%	YES
No EOB Code Provided		**246**	**2.65%**	
No EOB Code	No EOB Description	246	2.65%	
Time Filing Limit		**169**	**1.82%**	
29	The time limit for filing has expired	169	1.82%	
Coordination of Benefits Issue		**60**	**0.65%**	
22	This care may be covered by another payer per coordination of benefits.	58	0.63%	
23	The impact of prior payer(s) adjudication including payments and/or adjustments.	2	0.02%	
Included in Global Payment		**24**	**0.26%**	
97	Payment is included in the allowance for another service/procedure.	24	0.26%	
Eligibility Issue		**7**	**0.08%**	
31	Claim denied as patient cannot be identified as our insured.	3	0.03%	
177	Patient has not met the required eligibility requirements.	2	0.02%	
27	Expenses incurred after coverage terminated.	1	0.01%	
ELIGI	Loss Of Medicaid Eligibility	1	0.01%	YES
Total		**9,269**		

Please note:
- All figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.
- A claim may have more than one denial reason code.
- M&S created 'Reason Groups' to categorize similar types of denials.
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjucidation were not included in the data submitted by the CMO.
- Internal EOB codes for which a HIPAA-compliant EOB code was not provided to us.

Georgia Department of Community Health
Georgia Families
Exhibit 3e - WellCare - Summary of Claim Denials Later Paid for CHOA
June 1, 2006 through August 31, 2007

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
June-06	59	2	3.39%	4	0	$0.00
July-06	165	50	30.30%	15	0	$0.00
August-06	505	17	3.37%	32	0	$0.00
September-06	426	24	5.63%	53	0	$0.00
October-06	589	63	10.70%	57	0	$0.00
November-06	345	33	9.57%	53	0	$0.00
December-06	1,959	311	15.88%	76	0	$0.00
January-07	461	115	24.95%	92	0	$0.00
February-07	247	54	21.86%	96	0	$0.00
March-07	362	141	38.95%	117	0	$0.00
April-07	383	49	12.79%	110	0	$0.00
May-07	266	27	10.15%	94	0	$0.00
June-07	367	30	8.17%	90	0	$0.00
July-07	384	67	17.45%	115	0	$0.00
August-07	326	27	8.28%	105	0	$0.00
Total	**6,844**	**1,010**	**14.76%**	**74 Days**	**0**	**$0.00**

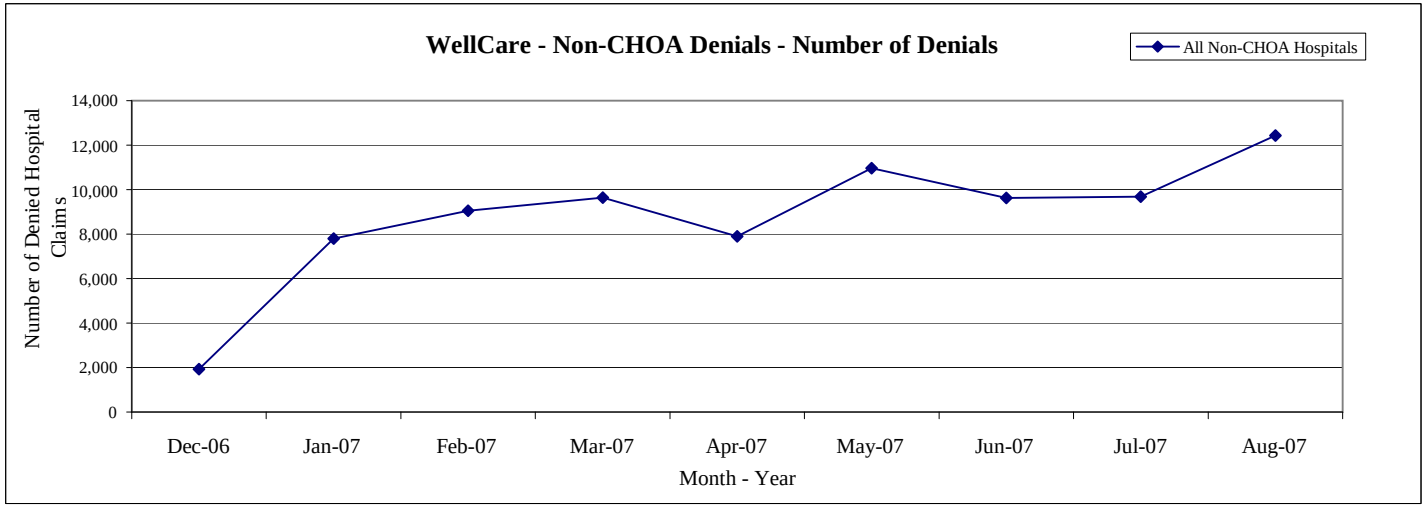
Please note that all figures reflect a distinct count of claims paid or denied between June 1, 2006 and August 31, 2007.

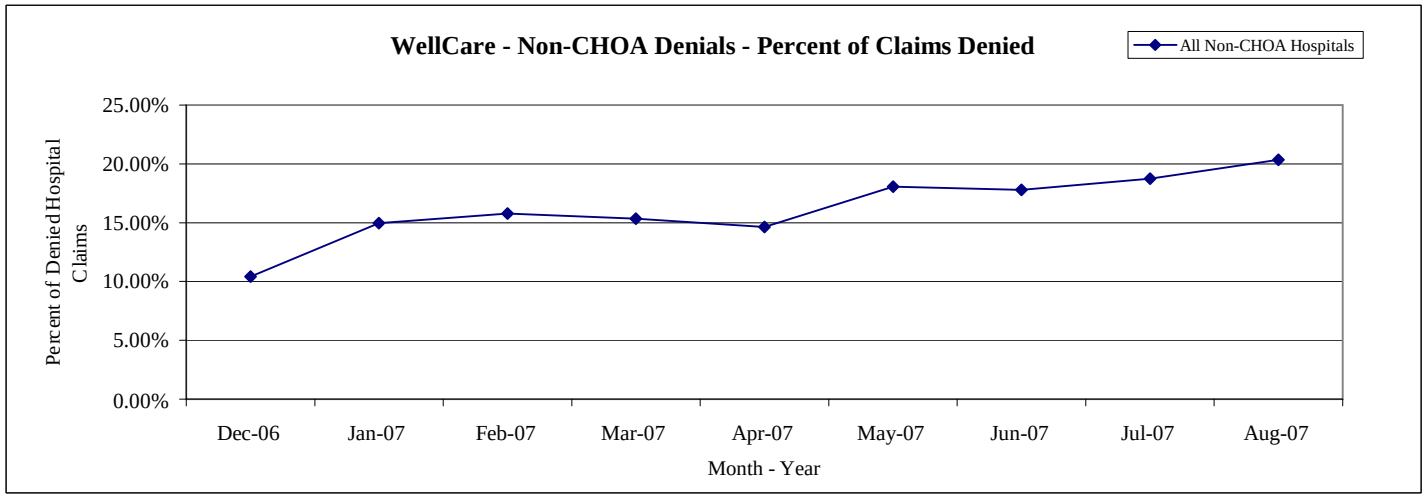


Georgia Department of Community Health
Georgia Families
Exhibit 3f - WellCare - Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

		Dec-06	Jan-07	Feb-07	Mar-07	Apr-07	May-07	Jun-07	Jul-07	Aug-07	TOTAL
All Non-CHOA Hospitals	**Paid Claims**	16,597	44,328	48,316	53,253	46,096	49,675	44,462	41,942	48,637	393,306
	Denied Claims	1,931	7,796	9,057	9,642	7,899	10,957	9,623	9,680	12,435	79,020
	Total Claims	18,528	52,124	57,373	62,895	53,995	60,632	54,085	51,622	61,072	472,326
	Percent Denied	10.42%	14.96%	15.79%	15.33%	14.63%	18.07%	17.79%	18.75%	20.36%	16.73%

Please note that all figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.





Georgia Department of Community Health
Georgia Families
Exhibit 3f - WellCare - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials	Internal EOB
Included in Global Payment		**28,622**	**27.64%**	
97	Payment is included in the allowance for another service/procedure.	28,617	27.64%	
97	Payment is included in the allowance for another service/procedure.	3	0.00%	
59	Charges are adjusted based on multiple surgery rules or concurrent anesthesia rules.	1	0.00%	
24	Payment for charges adjusted. Charges are covered under a capitation agreement/managed care plan.	1	0.00%	
Authorization Issue		**25,629**	**24.75%**	
197	Payment adjusted for absence of precertification/ authorization.	24,127	23.30%	
39	Services denied at the time authorization/pre-certification was requested.	698	0.67%	
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	504	0.49%	
M62	Missing/incomplete/invalid treatment authorization code.	172	0.17%	
198	Payment Adjusted for exceeding precertification/ authorization.	126	0.12%	
DNPA	Denied Not Preauthorized by the Plan	1	0.00%	YES
AUCST	AUTHORIZATION COST EXCEEDS	1	0.00%	YES
Fee, Service Limit, or Charge Issue		**18,493**	**17.86%**	
204	This service/equipment/drug is not covered under the patients current benefit plan	7,161	6.92%	
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	3,376	3.26%	
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	2,721	2.63%	
94	Processed in Excess of charges.	1,836	1.77%	
A1	Claim denied charges	1,592	1.54%	
WCPNP	WHOLE CLAIM PRICE - NO PRICING	815	0.79%	YES
HRM21	Services are Non-covered in the Outpatient Hospital Program	751	0.73%	YES
96	Non-covered charge(s).	202	0.20%	

Georgia Department of Community Health
Georgia Families
Exhibit 3f - WellCare - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials	Internal EOB
119	Benefit maximum for this time period or occurrence has been reached.	31	0.03%	
RV106	OVERPAYMENT	2	0.00%	YES
B7	This provider was not certified/eligible to be paid for this procedure/service on this date of service.	2	0.00%	
B5	Coverage/program guidelines were not met or were exceeded.	2	0.00%	
35	Benefit maximum has been reached.	2	0.00%	
Incorrect/Invalid Information		**13,715**	**13.25%**	
181	Payment adjusted because this procedure code was invalid on the date of service	11,491	11.10%	
B18	Payment denied because this procedure code/modifier was invalid on the date of service or claim submission.	1,760	1.70%	
5	The procedure code/bill type is inconsistent with the place of service.	288	0.28%	
16	Claim/service lacks information which is needed for adjudication. Additional information is supplied using remittance advice remarks	174	0.17%	
125	Payment adjusted due to a submission/billing error(s). Additional information is supplied using the remittance advice remarks codes	1	0.00%	
DNCFM	Consent form missing or incomplete	1	0.00%	YES
Duplicate Submission		**11,124**	**10.74%**	
18	Duplicate claim/service.	9,399	9.08%	
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	1,073	1.04%	
PODUP	POTENTIAL DUPLICATE	652	0.63%	YES
Claim Submission Error		**3,139**	**3.03%**	
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	3,135	3.03%	
DORAL	PLEASE SUBMIT CLAIM TO DORAL DENTAL	3	0.00%	YES
RV105	PROVIDER BILLING ERROR	1	0.00%	YES
Time Filing Limit		**946**	**0.91%**	
29	The time limit for filing has expired	946	0.91%	

Georgia Department of Community Health
Georgia Families
Exhibit 3f - WellCare - Summary of Claim Denials for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Reason Code / Group	Reason Description	Claim Count	Percent of All Denials	Internal EOB
Coordination of Benefits Issue		**817**	**0.79%**	
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	680	0.66%	
23	Payment adjusted because charges have been paid by another payer	120	0.12%	
COB	Possible COB claim	17	0.02%	YES
No EOB Code Provided		**797**	**0.77%**	
No EOB Code	No EOB Description	797	0.77%	YES
Eligibility Issue		**258**	**0.25%**	
31	Claim denied as patient cannot be identified as our insured.	251	0.24%	
177	Patient has not met the required eligibility requirements.	4	0.00%	
N216	Patient is not enrolled in this portion of our benefit package	1	0.00%	
27	Expenses incurred after coverage terminated.	1	0.00%	
26	Expenses incurred prior to coverage.	1	0.00%	
Total		**103,540**		

Please note:
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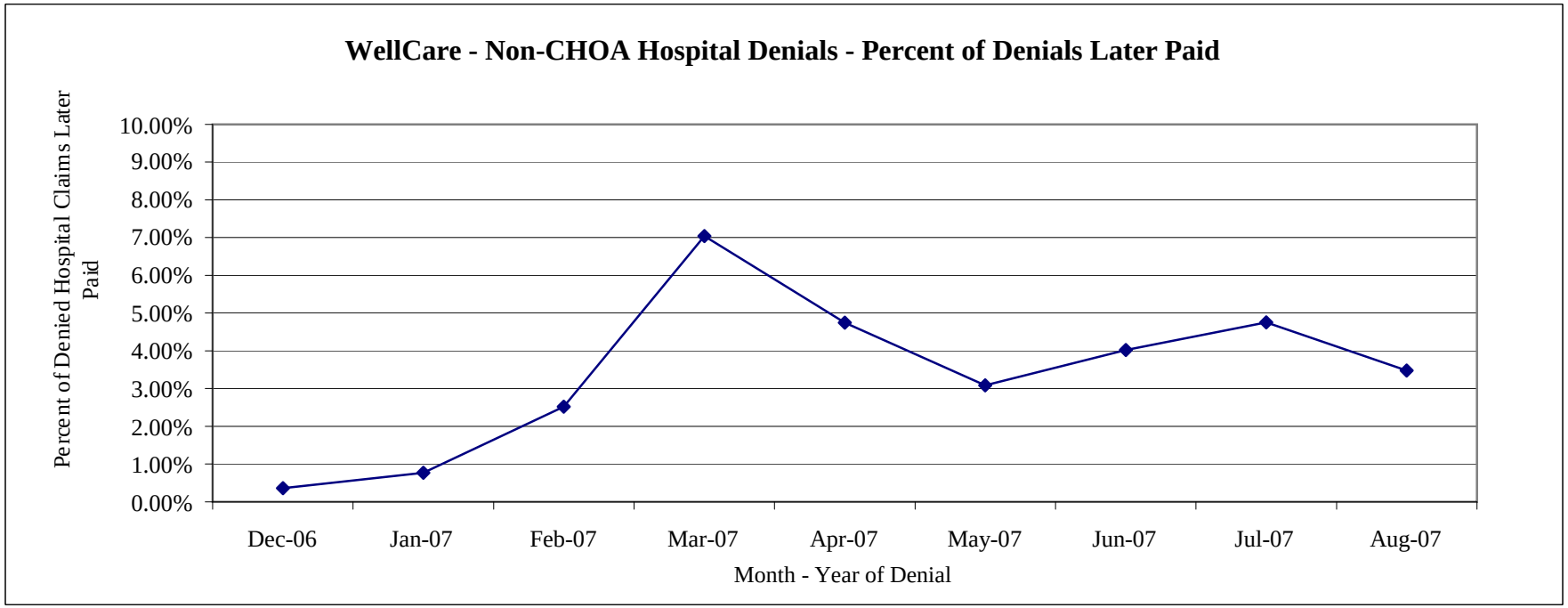
- Denial reasons only exist on claims that are adjudicated. Claims rejected prior to adjucidation were not included in the data submitted by the CMO.
- Internal EOB codes for which a HIPAA-compliant EOB code was not provided to us.

Georgia Department of Community Health
Georgia Families
Exhibit 3f - WellCare - Summary of Claim Denials Later Paid for Non-CHOA Hospitals
December 1, 2006 through August 31, 2007

Month	Number of Denials	Number of Denials Later Paid	Percentage of Denials Later Paid	Average Length of Time Between Denial and Payment	Number of Interest Payments	Amount of Interest Paid
December-06	1,931	7	0.36%	6	0	$0.00
January-07	7,796	60	0.77%	17	0	$0.00
February-07	9,057	228	2.52%	29	0	$0.00
March-07	9,642	679	7.04%	43	0	$0.00
April-07	7,899	375	4.75%	52	0	$0.00
May-07	10,957	338	3.08%	62	0	$0.00
June-07	9,623	387	4.02%	71	0	$0.00
July-07	9,680	460	4.75%	77	0	$0.00
August-07	12,435	433	3.48%	70	0	$0.00
Total	**79,020**	**2,967**	**3.75%**	**47 Days**	**0**	**$0.00**

Please note that all figures reflect a distinct count of claims paid or denied between December 1, 2006 and August 31, 2007.



Georgia Department of Community Health
Georgia Families
Exhibit 4a - AMERIGROUP - Suspended Hospital Claims - CHOA
Claims Pending as of July 1, 2007

Provider Name	Claim Count	Billed Amount
Children's Healthcare of Atlanta at Egleston	30	$147,280.50
Children's Healthcare of Atlanta at Scottish Rite	2	$2,144.75
TOTAL	**32**	**$149,425.25**

Georgia Department of Community Health
Georgia Families
Exhibit 4a - AMERIGROUP - Suspended CHOA Claims by Month Received
Claims Pending as of July 1, 2007

Month and Year Initially Pended	Claim Count	Billed Amount of Pended Claims
June 2006	32	$149,425.25
July 2006 to June 2007	0	$0.00
TOTAL	**32**	**$149,425.25**

Georgia Department of Community Health
Georgia Families
Exhibit 4a - AMERIGROUP - Suspended CHOA Hospital Claims by Reason Code
Claims Pending as of July 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pending Claims
Authorization / Medical Management Issue		**37**	**82.22%**
Z118	Preauthorization violation-Pen	26	57.78%
C010	MCR review	4	8.89%
Z106	Pend to MCR for review	3	6.67%
Z126	Prospective UM notes exist	2	4.44%
HP00	Pend - Health Plan Auth Review	1	2.22%
C013	MCR HistoryChecker review	1	2.22%
Claim Review		**7**	**15.56%**
Z146	Use override on separate line	3	6.67%
C051	Pend to Claims Team for review	2	4.44%
C025	UB92 Corrected Claim	1	2.22%
BC02	BC for pricing	1	2.22%
Miscellaneous		**1**	**2.22%**
	No Pending Reason Provided	1	2.22%
		45	

A claim may be pended for more than one reason. Actual claim count is 32 claims.

Georgia Department of Community Health
Georgia Families
Exhibit 4b - AMERIGROUP - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of July 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
Grady Memorial Hospital	18	$353,876.93	11%
Medical College of GA	31	$232,179.58	7%
East Georgia Regional Medical Ctr	7	$215,988.21	7%
Southern Regional Medical Ctr	8	$206,913.36	6%
Memorial Health University Medical Ctr	7	$199,219.20	6%
Wellstar Kennestone Hospital	8	$165,472.50	5%
Doctors Hospital of Augusta	29	$163,388.20	5%
Northeast Georgia Medical Center	12	$159,107.19	5%
Athens Regional Medical Ctr	25	$121,534.57	4%
Hamilton Medical Ctr	46	$120,159.16	4%
Hughes Spalding Children's Hospital	10	$110,432.46	3%
Wellstar Cobb Hospital	14	$109,000.02	3%
Cartersville Medical Center	10	$100,538.32	3%
Northside Hospital	7	$96,702.00	3%
University Hospital	19	$90,759.14	3%
Emory Crawford Long Hospital	9	$74,629.73	2%
St Mary's Hospital	21	$73,376.40	2%
Southeast Georgia Health System - Brunswick Campus	17	$67,826.30	2%
Hutcheson Medical Ctr	13	$56,496.12	2%
Northside Hospital-Cherokee	4	$45,033.50	1%
Murray Medical Center	4	$33,640.81	1%
Wellstar Windy Hill Hospital	7	$31,512.75	1%
Walton Regional Medical Ctr	3	$29,697.56	1%
Appling Healthcare System	3	$28,431.54	1%
Polk Medical Center	2	$26,774.78	1%
Henry Medical Center	5	$25,947.80	1%
Candler Hospital	4	$23,619.86	1%
Habersham County Medical Ctr	2	$18,914.53	1%
Piedmont Hospital	2	$17,745.70	1%
Emory Eastside Medical Center	2	$16,622.79	1%
Burke Medical Center	4	$16,587.54	1%
Stephens County Hospital	13	$16,246.99	1%
Gwinnett Hospital Systems	1	$15,235.00	0%
Tanner Medical Center Carrollton	5	$13,530.48	0%
Chestatee Regional Hospital	5	$11,656.75	0%
Newton Medical Ctr	6	$11,450.16	0%
Redmond Regional Medical Ctr	4	$10,201.52	0%
St Joseph's Hospital	2	$10,052.45	0%
Piedmont Mountainside Hospital	1	$9,536.60	0%

Georgia Department of Community Health
Georgia Families
Exhibit 4b - AMERIGROUP - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of July 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
Fannin Regional Hospital	4	$9,073.52	0%
Piedmont Fayette Hospital	3	$8,948.00	0%
Liberty Regional Medical Ctr	2	$8,415.25	0%
Higgins General Hospital	1	$8,040.00	0%
Meadows Regional Medical Ctr	2	$7,057.20	0%
Emory Adventist Hospital	2	$6,213.08	0%
Rockdale Medical Center	4	$5,664.42	0%
Wellstar Douglas Hospital	2	$5,094.25	0%
Southeast Georgia Health System - Camden Campus	1	$5,015.30	0%
Satilla Regional Med Center	1	$4,472.60	0%
Jefferson Hospital	1	$3,659.50	0%
Chatuge Regional Hospital	1	$3,581.00	0%
Wayne Memorial Hospital	4	$2,863.71	0%
Northside Hospital-Forsyth	1	$2,841.50	0%
BJC Medical Center	1	$2,276.84	0%
Emanuel Medical Ctr	1	$1,874.00	0%
Cobb Memorial Hospital	5	$1,596.00	0%
North Georgia Medical Ctr	1	$1,578.00	0%
Wills Memorial Hospital	1	$1,400.00	0%
Putnam General Hospital	2	$845.32	0%
Barrow Regional Medical Ctr	2	$772.58	0%
Jenkins County Hospital	1	$546.00	0%
Hart County Hospital	2	$480.00	0%
Evans Memorial Hospital	1	$325.00	0%
WellStar Paulding Hospital	1	$230.00	0%
McDuffie County Hospital	3	$219.25	0%
Elbert Memorial Hospital	1	$171.00	0%
Emory University Hospital	1	$99.00	0%
Effingham Hospital	1	$39.00	0%
TOTAL	**443**	**$3,223,429.82**	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Georgia Department of Community Health
Georgia Families
Exhibit 4b - AMERIGROUP - Suspended Non-CHOA Hospital Claims by Month Received
Claims Pending as of July 1, 2007

Month and Year Initially Pended	Claim Count	Billed Amount of Pended Claims
December 2006 to April 2006	0	$0.00
May 2007	2	$15,440.85
June 2007	441	$3,207,988.97
TOTAL	**443**	**$3,223,429.82**

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Georgia Department of Community Health
Georgia Families
Exhibit 4b - AMERIGROUP - Suspended Non-CHOA Hospital Claims by Reason Code
Claims Pending as of July 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pending Claims
Authorization / Medical Management Issue		**404**	**61.12%**
Z118	Preauthorization violation-Pen	287	43.42%
C010	MCR review	38	5.75%
Z106	Pend to MCR for review	20	3.03%
Z081	Multiple UM pre-authorizations	15	2.27%
C013	MCR HistoryChecker review	11	1.66%
C014	MCR Issue Resolved	10	1.51%
MM00	Pend - NCC Auth Review	9	1.36%
HP00	Pend - Health Plan Auth Review	5	0.76%
BH01	BH Care Management	3	0.45%
Z126	Prospective UM notes exist	3	0.45%
C012	OB authorization required	2	0.30%
C009	MCR-OON DME Not on Schedule	1	0.15%
Claim Review		**196**	**29.65%**
C050	High Dollar review	58	8.77%
C051	Pend to Claims Team for review	33	4.99%
Z038	Duplicate claims on file for t	28	4.24%
C006	COB review	18	2.72%
C058	Incorrectly pended to Bus Sol	13	1.97%
BC02	BC for pricing	12	1.82%
Z146	Use override on separate line	6	0.91%
C054	Pend to Claim Supervisor	5	0.76%
C059	Claim missing an ACLAP entry	3	0.45%
BH00	Claims BH Team	3	0.45%
C061	Corrected Claim-Web Submission	3	0.45%
C055	Anesthesia Units Review	2	0.30%
PC03	Clms incor tied to prv grp	2	0.30%
C052	IP DRG HSS/Pricing Issues	2	0.30%
A013	Coding and/or Fee Issue	1	0.15%
BC05	Agreement Assignment	1	0.15%
TX00	Claims Texas Team	1	0.15%
P002	Observation Units >48	1	0.15%
C024	OPRC-01-Error Accessing Payor	1	0.15%
C065	Newborn Claims	1	0.15%

Georgia Department of Community Health
Georgia Families
Exhibit 4b - AMERIGROUP - Suspended Non-CHOA Hospital Claims by Reason Code
Claims Pending as of July 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pending Claims
P001	TX SNP Harris Co Carve Outs	1	0.15%
C025	UB92 Corrected Claim	1	0.15%
Miscellaneous		**61**	**9.23%**
	No Pending Reason Provided	43	6.51%
PC00	Provider Configuration	14	2.12%
P004	Hierarchy Payment Conflict	4	0.61%
		661	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

A claim may be pended for more than one reason. Actual claim count is 443 claims.

Georgia Department of Community Health
Georgia Families
Exhibit 4c - Peach State Health Plan - Suspended Hospital Claims - CHOA
Claims Pending as of September 1, 2007

Provider Name	Claim Count	Billed Amount
CHILDRENS HLTH CARE OF ATL EGLESTON	13	$769,962.45
SCOTTISH RITE CHILDRENS MED CTR	11	$120,117.25
TOTAL	**24**	**$890,079.70**

Georgia Department of Community Health
Georgia Families
Exhibit 4c - Peach State Health Plan - Suspended CHOA Claims by Month Received
Claims Pending as of September 1, 2007

Month and Year Initially Pended	Claim Count	Billed Amount
July 2006	1	$363.00
May 2007	1	$62,562.25
June 2007	8	$135,562.70
July 2007	14	$691,591.75
TOTAL	**24**	**$890,079.70**

Georgia Department of Community Health
Georgia Families
Exhibit 4c - Peach State Health Plan - Suspended CHOA Hospital Claims by Reason Code
Claims Pending as of September 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pening Claims
Claim Issue		**13**	**54.17%**
**	**DO NOT DELETE** HISTORICAL EX CODE	4	16.67%
LL	PEND: CLAIM IS SET TO PAY OVER AUDIT AMOUNT ($10,000 FOR H, $5000 FOR M)	4	16.67%
U2	PEND: UNLISTED PROCEDURE NEED RECORDS TO PROCESS	2	8.33%
GK	PEND TO CSS	1	4.17%
C3	PEND: POSSIBLE DUPLICATE SERVICE	1	4.17%
S9	PEND: REFER TO WORK PROCESS FOR BILATERAL SURGERY PROCESSING	1	4.17%
Authorization Issue		**9**	**37.50%**
SP	PEND: REVIEW FOR SPECIAL CONSIDERATION - LOOK FOR AUTH	5	20.83%
A6	PEND: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	2	8.33%
UJ	PEND: UR REVIEWING DOCUMENTATION	1	4.17%
AU	PEND: MULTIPLE AUTHORIZATIONS QUALIFY, PICK CORRECT AUTH.#	1	4.17%
Provider Set Up Issue		**2**	**8.33%**
NQ	PROVIDER SET-UP PROBLEM, SEND TO NETWORK QUALITY DEPARTMENT	2	8.33%
		24	

Georgia Department of Community Health
Georgia Families
Exhibit 4d - Peach State Health Plan - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of September 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
PHOEBE PUTNEY MEMORIAL HOSPITAL	398	$766,822.56	12%
ATLANTA MEDICAL CENTER-TENET	10	$724,881.70	11%
MEDICAL CENTER INC	60	$529,585.15	8%
ROCKDALE MEDICAL CENTER	15	$473,128.94	7%
HENRY MEDICAL CENTER	20	$437,264.46	7%
GRADY HEALTH SYSTEM	8	$399,829.44	6%
SPALDING REGIONAL HOSPITAL	152	$359,159.77	6%
SOUTH GEORGIA MEDICAL CENTER	434	$308,348.77	5%
SOUTH FULTON MEDICAL CTR TENET	10	$247,509.59	4%
MEDICAL CENTER OF CENTRAL GA	14	$223,475.18	3%
ST JOSEPH HOSPITAL OF ATLANTA	10	$186,238.50	3%
DEKALB MEDICAL CENTER	16	$168,457.80	3%
NORTHSIDE HOSPITAL	12	$131,226.00	2%
UPSON REGIONAL MEDICAL CENTER	126	$129,589.79	2%
COLISEUM MEDICAL CENTER	11	$92,832.00	1%
EMORY EASTSIDE MEDICAL CENTER	6	$89,887.52	1%
COLISEUM NORTHSIDE HOSPITAL	89	$77,458.50	1%
CRISP REGIONAL HOSP	74	$74,818.26	1%
TIFT GENERAL MEDICAL CENTER	21	$68,797.12	1%
CARTERSVILLE MEDICAL CENTER	3	$59,346.75	1%
GWINNETT MEDICAL CENTER	10	$53,224.38	1%
FAIRVIEW PARK HOSPITAL	7	$51,477.06	1%
ARCHBOLD MEDICAL CENTER	5	$51,447.00	1%
SMITH NORTHVIEW HOSPITAL	9	$49,450.00	1%
EMORY UNIVERSITY HOSPITAL	1	$48,389.34	1%
COLQUITT REGIONAL HOSPITAL	15	$44,380.03	1%
PHOEBE PUTNEY MEMORIAL HOSPITAL	14	$43,640.59	1%
NORTHSIDE HOSPITAL- CHEROKEE	9	$43,454.50	1%
WEST GEORGIA MEDICAL CTR	16	$42,625.95	1%
PIEDMONT HOSPITAL	4	$35,735.75	1%
EMORY CRAWFORD LONG HOSPITAL	11	$34,574.97	1%
DEKALB MEDICAL CENTER AT HILLANDALE	4	$26,813.90	0%
SOUTHERN REGIONAL MEDICAL CENTER	6	$25,773.80	0%
WEST HOUSTON MED CTR INC	1	$20,995.58	0%
ROOSEVELT WARM SPRINGS INST FOR REHA	3	$18,430.00	0%

Georgia Department of Community Health
Georgia Families
Exhibit 4d - Peach State Health Plan - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of September 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
WARM SPRINGS MEDICAL CENTER	10	$17,850.05	0%
SGHS BRUNSWICK CAMPUS	5	$16,976.75	0%
SATILLA REGIONAL MEDICAL CTR	5	$16,692.35	0%
HUGHES SPALDING CHILDRENS HOSP	4	$13,464.05	0%
PALMYRA MEDICAL CENTER	3	$12,938.12	0%
HUGHSTON SPORTS MEDICINE HOSPITAL	3	$12,616.25	0%
DONALSONVILLE HOSPITAL	3	$12,208.00	0%
GRADY GENERAL HOSPITAL	3	$12,154.00	0%
HARLEM HOSPITAL CENTER	1	$11,318.72	0%
DORMINY MEDICAL CENTER	2	$10,752.44	0%
MEMORIAL HOSPITAL OF ADEL	3	$10,196.80	0%
OCONEE REGIONAL MEDICAL CENTER	8	$9,607.81	0%
IRWIN COUNTY HOSPITAL	2	$9,184.43	0%
LOUIS SMITH MEMORIAL HOSPITAL	1	$8,814.00	0%
JASPER MEMORIAL HOSPITAL AND REHAB	4	$7,100.52	0%
DODGE COUNTY HOSP	3	$6,953.83	0%
BROOKS COUNTY HOSPITAL	5	$6,530.00	0%
EMANUEL COUNTY HOSPITAL	4	$6,152.00	0%
PIEDMONT NEWNAN HOSPITAL	1	$6,100.45	0%
NEWTON MEDICAL CENTER	1	$5,721.35	0%
HIGGINS GENERAL HOSPITAL	1	$5,175.00	0%
MITCHELL COUNTY HOSPITAL	3	$5,162.00	0%
TANNER MEDICAL CENTER-CARROLLTON	3	$5,153.54	0%
TAYLOR REGIONAL HOSPITAL	2	$4,937.00	0%
PERRY HOSPITAL	3	$4,413.94	0%
CLINCH MEMORIAL HOSPITAL	1	$4,291.13	0%
EARLY MEMORIAL HOSPITAL	1	$3,557.00	0%
CALHOUN MEMORIAL HOSPITAL	2	$3,361.00	0%
SOUTHEAST ALABAMA MED CTR	2	$3,355.00	0%
DOCTORS HOSPITAL OF COLUMBUS	2	$3,287.00	0%
SYLVAN GROVE HOSPTIAL TENET	2	$3,238.75	0%
MEMORIAL HOSPITAL AND MANOR	5	$2,293.00	0%
TCT CHILDRENS HOSPITAL	2	$2,236.00	0%
MEMORIAL HEALTH UNIVERSITY MED CTR	5	$2,233.93	0%
MONROE COUNTY HOSPITAL	2	$2,125.35	0%

Georgia Department of Community Health
Georgia Families
Exhibit 4d - Peach State Health Plan - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of September 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
PIEDMONT FAYETTE HOSPITAL	5	$2,093.00	0%
JOAN GLANCY MEMORIAL HOSPITAL	3	$1,824.00	0%
ST FRANCIS HOSPITAL	3	$1,697.25	0%
FLOYD MEDICAL CENTER	2	$1,288.00	0%
W CALCASIEU CAMERON HOSPITAL	1	$941.00	0%
TANNER MEDICAL CENTER- VILLA RICA	1	$872.00	0%
PHOEBE WORTH HOSPITAL	14	$870.00	0%
CHILDRENS MEMORIAL HOSPITAL	1	$759.40	0%
NORTH GEORGIA MEDICAL CENTER	2	$656.00	0%
REDMOND REGIONAL MEDICAL CENTER	1	$509.00	0%
NORTH FULTON REGION HOSP TENET	1	$456.90	0%
UTAH VALLEY REG MED CNTR	1	$402.65	0%
MEDICAL COLLEGE OF GEORGIA HOSPITAL	2	$377.20	0%
BERRIEN COUNTY HOSPITAL	1	$355.00	0%
O BLENESS MEMORIAL HOSPITAL	1	$301.98	0%
GORDON HOSPITAL	1	$278.50	0%
BARROW REGIONAL MEDICAL CENTER	1	$272.25	0%
ELBERT MEMORIAL HOSPITAL	1	$146.50	0%
TOTAL	**1,753**	**$6,421,322.84**	

Georgia Department of Community Health
Georgia Families
Exhibit 4d - Peach State Health Plan - Suspended Non-CHOA Hospital Claims by Month Received
Claims Pending as of September 1, 2007

Month and Year Initially Pended	Claim Count	Billed Amount
July 2006	1	$6,408.00
August 2006	3	$23,545.98
September 2006	3	$10,416.92
October 2006	13	$355,904.67
November 2006	10	$50,565.98
December 2006	7	$34,542.63
January 2007	2	$17,696.70
February 2007	7	$63,209.56
March 2007	8	$33,902.77
April 2007	19	$106,634.12
May 2007	79	$451,074.90
June 2007	1,465	$4,660,147.82
July 2007	136	$607,272.79
TOTAL	**1,753**	**$6,421,322.84**

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Georgia Department of Community Health
Georgia Families
Exhibit 4d - Peach State Health Plan - Suspended Non-CHOA Hospital Claims by Reason Code
Claims Pending as of September 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pening Claims
Provider Set Up Issue		**1,311**	**74.79%**
Y7	PEND: PROVIDER SET-UP ISSUE, PLEASE REVIEW AND CORRECT	1,076	61.38%
NQ	PROVIDER SET-UP PROBLEM, SEND TO NETWORK QUALITY DEPARTMENT	233	13.29%
DA	PEND: PROVIDER-SPECIFIC FEE NOT FOUND	2	0.11%
Claim Issue		**318**	**18.14%**
DR	PEND: MANUALLY CALCULATE DRG#, DIAG NOT GROUPABLE OR ENTER BIRTH WEIGHT	64	3.65%
C3	PEND: POSSIBLE DUPLICATE SERVICE	55	3.14%
TP	ROUTE TO TPL DEPARTMENT - OTHER INSURANCE	31	1.77%
YY	PEND: CLAIMS PROCESSING REVIEW	23	1.31%
GK	PEND TO CSS	22	1.25%
S9	PEND: REFER TO WORK PROCESS FOR BILATERAL SURGERY PROCESSING	19	1.08%
EZ	ROUTE TO CLAIMS MANAGER	15	0.86%
L9	PEND: T-19 MEMBER HAS OTHER INSURANCE - NEED TO VERIFY.	14	0.80%
CF	PEND: WAITING FOR CONSENT FORM	13	0.74%
**	**DO NOT DELETE** HISTORICAL EX CODE	10	0.57%
LL	PEND: CLAIM IS SET TO PAY OVER AUDIT AMOUNT ($10,000 FOR H, $5000 FOR M)	10	0.57%
66	CODE IS BEING QUESTIONED BY CODE AUDITING SOFTWARE	7	0.40%
DF	PEND: MANUAL PRICING REQUIRED	6	0.34%
VO	VOID SERVICE FOR ADMINISTATIVE REASONS	5	0.29%
U2	PEND: UNLISTED PROCEDURE NEED RECORDS TO PROCESS	4	0.23%
A4	PEND: MATERNITY ANESTHESIA MANUALLY CALCULATE PAYMENT	3	0.17%
28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED	3	0.17%
YP	PEND: DUPLICATE PROVIDERS FOUND WITH THE SAME IRS# & MEDICAID#	3	0.17%
R2	PEND: PROVIDER REQUIRES AN AREA CODE / SPECIFIC PROV RATE ON FEE SCHED	3	0.17%
M0	PEND: MEMBER PARTIALLY ELIGIBLE AT TIME OF SERVICE	2	0.11%
M2	PEND: MANUAL PRICING REQUIRED - SEE WORK PROCESS FOR MULTIPLE SURGERY	2	0.11%
CQ	PEND: SPLIT SERVICES TO CAPTURE CORRECT UNITS BILLED	1	0.06%
X9	PEND: PENDED BY AUDITOR	1	0.06%
X1	PENDED BY AUDITOR	1	0.06%
D7	PEND: LIMITED TO EXCEEDED OR MISSING KEYWORD	1	0.06%
Miscellaneous		**89**	**5.08%**
ZZ	PEND: ROUTE TO INFORMATION SERVICES "IS" DEPARTMENT	89	5.08%
Authorization Issue		**35**	**2.00%**
A6	PEND: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	15	0.86%

Georgia Department of Community Health
Georgia Families
Exhibit 4d - Peach State Health Plan - Suspended Non-CHOA Hospital Claims by Reason Code
Claims Pending as of September 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pening Claims
UJ	PEND: UR REVIEWING DOCUMENTATION	9	0.51%
PE	PEND: PROVIDER IS ON REVIEW	3	0.17%
9G	PEND: MRU REVIEWING CLAIM	3	0.17%
SP	PEND: REVIEW FOR SPECIAL CONSIDERATION - LOOK FOR AUTH	2	0.11%
PM	PEND: PCP IS NOT EFFECTIVE AT THE TIME OF SERVICE	2	0.11%
HB	PEND: CLAIM AND AUTH DATES OF ADMISSION NOT MATCHING	1	0.06%
		1,753	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Georgia Department of Community Health
Georgia Families
Exhibit 4e - WellCare - Suspended Hospital Claims - CHOA
Claims Pending as of November 1, 2007

Provider Name	Claim Count	Billed Amount
CHOA AT EGLESTON	6,894	$51,381,660.10
CHOA AT SCOTTISH RITE	9,521	$38,072,375.72
TOTAL	**16,415**	**$89,454,035.82**

Georgia Department of Community Health
Georgia Families
Exhibit 4e - WellCare - Suspended CHOA Claims by Month Received
Claims Pending as of November 1, 2007

Month and Year Initially Pended	Claim Count	Billed Amount
No Pend Date	190	$1,001,721.00
June 2006	10	$86,248.75
July 2006	88	$269,191.75
August 2006	431	$1,387,761.74
September 2006	760	$1,942,356.34
October 2006	979	$4,253,213.29
November 2006	716	$3,264,774.59
December 2006	1,014	$4,247,997.00
January 2007	978	$3,145,587.39
February 2007	640	$2,511,168.80
March 2007	1,010	$4,436,978.51
April 2007	520	$4,395,121.00
May 2007	310	$3,743,191.50
June 2007	188	$1,567,820.25
July 2007	1,274	$7,368,292.59
August 2007	1,097	$6,132,975.84
September 2007	3,098	$19,845,642.35
October 2007	2,919	$18,489,848.88
November 2007	193	$1,364,144.25
TOTAL	**16,415**	**$89,454,035.82**

Georgia Department of Community Health
Georgia Families
Exhibit 4e - WellCare - Suspended CHOA Hospital Claims by Reason Code
Claims Pending as of November 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pening Claims
Authorization / Medical Management Issue		**13,944**	**63.98%**
CLATH	Requires Authorization	7,700	35.33%
MLATH	Multiple Auths Hold	4,023	18.46%
VSTER	Authorization Exceeds Day Visits	2,060	9.45%
AUCST	Authorization Cost Exceeds	79	0.36%
COB	Possible COB Claim	69	0.32%
AUHEL	Authorization Held	10	0.05%
UADMR	Under Administrative Review	1	0.00%
AUTNW	Authorization Is New	1	0.00%
DN001	Prior Authorization Is Required But Was Not Obtained	1	0.00%
Claim Review		**7,849**	**36.02%**
PODUP	Potential Duplicate	3,901	17.90%
NDC	Claim Held For Entry Of NDC Number	2,104	9.65%
DUPLM	Potential Duplicate Claim	398	1.83%
CL081	Transplant Case - Urn Rate Applicable	363	1.67%
DOLLR	Security - Dollar Threshold Exceeded	354	1.62%
HIGH$	High Dollar Threshold- Please Review	316	1.45%
HRM02	Rev/CPT Reversal Required	257	1.18%
CLMAN	Claim Requires Manual Intervention	110	0.50%
RV012	Req'd Refund; Awaiting Reimbursement From Provider	26	0.12%
SEGUP	Segment Update	13	0.06%
COBOC	Undefined Other Carrier Code For COB	4	0.02%
WCPNP	Whole Claim Price - No Pricing	1	0.00%
LIMIT	Benefit Maximum Has Been Reached.	1	0.00%
CTRSH	Held For Internal Research	1	0.00%
	TOTAL	**21,793**	

A claim may be pended for more than one reason. Actual claim count is 16,415 claims.

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of November 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
MEDICAL CENTER OF CENTRAL GEORGIA	9,261	$23,922,924.09	5%
THE MEDICAL CENTER	5,376	$21,845,429.02	5%
TCT CHILDRENS HOSPITAL	855	$21,246,390.22	5%
MEMORIAL HEALTH UNIVERSITY MED CTR	4,561	$21,009,523.03	5%
MEDICAL COLLEGE OF GEORGIA	10,455	$19,229,470.53	4%
GRADY MEMORIAL HOSPITAL	10,067	$17,215,236.09	4%
FLOYD MEDICAL CENTER	2,560	$15,819,211.68	4%
ATLANTA MEDICAL CENTER	1,013	$14,471,834.00	3%
NORTHSIDE HOSPITAL	1,647	$14,423,129.74	3%
SOUTH FULTON MEDICAL CENTER	1,183	$13,719,751.26	3%
WELLSTAR COBB HOSPITAL	2,997	$12,618,059.39	3%
DOCTORS HOSPITAL	1,237	$10,363,674.78	2%
ATHENS REGIONAL MEDICAL CENTER	3,065	$9,826,680.59	2%
NORTHEAST GEORGIA MEDICAL CENTER	2,094	$9,494,921.81	2%
GWINNETT MEDICAL CENTER	3,911	$9,295,869.21	2%
KENNESTONE HOSPITAL	2,288	$8,691,398.54	2%
SOUTHERN REGIONAL MED CTR	1,644	$7,555,769.57	2%
EMORY UNIVERSITY HOSPITAL - MAIN	454	$7,367,193.33	2%
UNIVERSITY HOSPITAL	1,472	$7,240,507.56	2%
HOUSTON MEDICAL CENTER	2,612	$7,208,307.01	2%
EMORY CRAWFORD LONG HOSPITAL	1,136	$6,961,279.91	2%
SPALDING REGIONAL MEDICAL CENTER	1,066	$6,552,275.10	1%
EAST GEORGIA REGIONAL MEDICAL CTR	1,149	$6,424,031.82	1%
ROCKDALE MEDICAL CENTER	2,065	$6,357,293.37	1%
CANDLER HOSPITAL	1,653	$6,193,779.36	1%
ST MARYS HEALTH CARE SYSTEM	1,198	$5,070,103.17	1%
CARTERSVILLE MEDICAL CENTER	1,009	$5,001,114.49	1%
HAMILTON MEDICAL CENTER	3,244	$4,657,112.04	1%
FAIRVIEW PARK HOSPITAL	1,084	$4,601,102.63	1%
HENRY MEDICAL CENTER	795	$4,320,122.32	1%
HUGHES SPALDING CHILDRENS HOSPITAL	5,179	$4,289,469.49	1%
SATILLA REGIONAL MEDICAL CENTER	1,464	$4,198,334.79	1%
COLISEUM MEDICAL CENTERS	521	$4,012,712.14	1%
TANNER MEDICAL CENTER	1,099	$3,733,578.31	1%
EMORY EASTSIDE MEDICAL CTR	554	$3,335,576.97	1%

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of November 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
REDMOND REGIONAL MEDICAL CTR	336	$3,309,522.87	1%
SE GEORGIA HEALTH SYS-BRUNSWICK CAMPUS	2,400	$3,050,060.53	1%
HUTCHESON MED CENTER	1,946	$3,013,523.36	1%
TIFT REGIONAL MEDICAL CENTER	804	$2,562,177.66	1%
MEADOWS REGIONAL MEDICAL CENTER	896	$2,511,906.13	1%
COFFEE REGIONAL MEDICAL CENTER	1,087	$2,441,978.35	1%
UPSON REGIONAL MEDICAL CENTER	1,007	$2,437,843.05	1%
FAYETTE COMMUNITY HOSPITAL	431	$2,417,782.28	1%
DOCTORS HOSPITAL	437	$2,365,123.65	1%
NEWTON MEDICAL CENTER	1,676	$2,328,156.47	1%
CRISP REGIONAL HOSPITAL	1,393	$2,274,097.78	1%
NORTH FULTON REGIONAL HOSPITAL	302	$2,184,280.75	0%
IRWIN COUNTY HOSPITAL	445	$2,112,265.34	0%
NEWNAN HOSPITAL	432	$2,083,856.05	0%
PARKRIDGE EAST HOSPITAL	226	$2,054,365.93	0%
DOUGLAS HOSPITAL	1,065	$2,014,299.19	0%
WALTON REGIONAL MEDICAL CTR	574	$1,935,156.62	0%
GORDON HOSPITAL	575	$1,849,123.14	0%
WAYNE MEMORIAL HOSPITAL	807	$1,800,035.68	0%
MOUNTAINSIDE MEDICAL CENTER	431	$1,792,033.71	0%
WEST GEORGIA MEDICAL CENTER	899	$1,643,050.77	0%
SUMTER REGIONAL HOSPITAL	567	$1,615,200.84	0%
STEPHENS COUNTY HOSPITAL	1,999	$1,514,841.16	0%
SOUTH GEORGIA MEDICAL CENTER	837	$1,483,987.17	0%
ERLANGER EAST HOSPITAL	63	$1,470,877.31	0%
NORTHSIDE HOSPITAL - FORSYTH	353	$1,457,999.04	0%
PIEDMONT HOSPITAL	157	$1,455,645.70	0%
CHESTATEE REGIONAL HOSPITAL	258	$1,404,876.86	0%
OCONEE REG MEDICAL CENTER	847	$1,351,903.23	0%
TAYLOR REGIONAL HOSPITAL	682	$1,325,779.98	0%
COLQUITT REGIONAL MEDICAL CTR	1,137	$1,321,453.83	0%
JOHN D ARCHBOLD MEMORIAL HOSP	210	$1,305,033.25	0%
APPLING HEALTHCARE SYSTEM	363	$1,289,720.32	0%
ST JOSEPHS HOSPITAL	327	$1,257,959.74	0%
PALMYRA MEDICAL CENTERS	210	$1,232,385.47	0%

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of November 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
FANNIN REGIONAL HOSPITAL	334	$1,215,794.38	0%
SE GEORGIA HEALTH SYSTEM-CAMDEN CAMPUS	1,346	$1,178,852.41	0%
DODGE COUNTY HOSPITAL	694	$1,055,980.43	0%
DONALSONVILLE HOSPITAL	327	$1,054,716.50	0%
TANNER MEDICAL CTR - VILLA RICA	423	$1,010,095.67	0%
NORTHSIDE HOSPITAL CHEROKEE	338	$982,353.80	0%
AUGUSTA HOSPITAL	720	$959,972.04	0%
BARROW REGIONAL MEDICAL CTR	313	$956,549.98	0%
PAULDING HOSPITAL	932	$955,952.74	0%
LIBERTY REGIONAL MEDICAL CENTER	417	$870,844.16	0%
EMANUEL MEDICAL CENTER	420	$860,637.00	0%
HUGHSTON ORTHOPEDIC HOSPITAL	59	$844,771.93	0%
COLISEUM NORTHSIDE HOSPITAL	125	$836,468.75	0%
SMITH NORTHVIEW HOSPITAL	194	$693,579.90	0%
HABERSHAM COUNTY MEDICAL CENTER	468	$674,534.62	0%
PERRY HOSPITAL	359	$663,264.48	0%
WINDY HILL HOSPITAL	103	$661,355.50	0%
FLINT RIVER HOSPITAL	212	$638,459.94	0%
BACON COUNTY HOSPITAL	326	$635,788.88	0%
COBB MEMORIAL HOSPITAL	657	$614,590.18	0%
NORTHLAKE MEDICAL CENTER	50	$609,572.44	0%
MURRAY MEDICAL CENTER	706	$607,709.28	0%
EVANS MEMORIAL HOSPITAL	340	$599,085.30	0%
ERLANGER BARONESS HOSPITAL	85	$578,463.50	0%
NORTH GEORGIA MEDICAL CENTER	898	$574,152.47	0%
BJC MEDICAL CENTER	188	$554,917.26	0%
UNION GENERAL HOSPITAL	798	$540,135.84	0%
WASHINGTON COUNTY REGIONAL MEDICAL CTR	401	$530,979.57	0%
BURKE MEDICAL CENTER	618	$517,209.35	0%
DORMINY MEDICAL CENTER	307	$508,112.87	0%
MILLER COUNTY HOSPITAL	192	$503,402.00	0%
NORTHEAST GEORGIA MED CTR-LANIER PARK	29	$455,306.53	0%
POLK MEDICAL CENTER	206	$406,749.87	0%
EMORY-ADVENTIST HOSPITAL	227	$406,690.21	0%
ELBERT MEMORIAL HOSPITAL	178	$374,880.20	0%

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of November 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
JEFF DAVIS HOSPITAL	230	$362,470.50	0%
PEACH REGIONAL MEDICAL CENTER	371	$352,754.55	0%
PARKRIDGE MEDICAL CENTER	38	$331,400.38	0%
HIGGINS GENERAL HOSPITAL	175	$309,194.32	0%
MCDUFFIE REGIONAL MEDICAL CENTER	167	$264,290.20	0%
MITCHELL COUNTY HOSPITAL	154	$261,252.95	0%
MEMORIAL HOSPITAL AND MANOR	244	$247,965.30	0%
MEMORIAL HOSPITAL OF ADEL	71	$225,607.97	0%
GRADY GENERAL HOSPITAL	122	$221,534.00	0%
MEMORIAL HOSPITAL	66	$199,465.45	0%
SYLVAN GROVE HOSPITAL	214	$197,875.60	0%
HART COUNTY HOSPITAL	258	$179,871.28	0%
WHEELER COUNTY HOSPITAL	97	$163,070.88	0%
JEFFERSON HOSPITAL	296	$159,455.95	0%
STEWART WEBSTER HOSPITAL	92	$153,344.08	0%
TAYLOR-TELFAIR REGIONAL HOSPITAL	134	$147,158.50	0%
WILLS MEMORIAL HOSPITAL	115	$144,055.39	0%
CLINCH MEMORIAL HOSPITAL	403	$138,785.67	0%
TATTNALL COMMUNITY HOSPITAL	67	$133,514.07	0%
MOUNTAIN LAKES MEDICAL CENTER	74	$123,464.23	0%
PUTNAM GENERAL HOSPITAL	122	$120,353.76	0%
EFFINGHAM HOSPITAL	164	$109,448.50	0%
MINNIE G BOWSELL MEMORIAL HOSPITAL	44	$104,273.35	0%
MONROE COUNTY HOSPITAL	157	$101,595.24	0%
CHATUGE REGIONAL HOSPITAL INC	70	$79,395.00	0%
CANDLER COUNTY HOSPITAL	54	$76,901.61	0%
WARM SPRINGS MEDICAL CENTER	48	$75,588.88	0%
EARLY MEMORIAL HOSPITAL	71	$74,015.00	0%
SCREVEN COUNTY HOSPITAL	56	$68,961.66	0%
BROOKS COUNTY HOSPITAL	43	$67,415.04	0%
BLECKLEY MEMORIAL HOSPITAL	114	$66,266.16	0%
SOUTHWEST GA REG MEDICAL	118	$62,106.75	0%
BERRIEN COUNTY HOSPITAL	36	$59,376.00	0%
JENKINS COUNTY HOSPITAL	85	$53,499.52	0%
CHARLTON MEMORIAL HOSPITAL	39	$53,225.46	0%

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Provider
Claims Pending as of November 1, 2007

Provider Name	Claim Count	Billed Amount	Percent of Total (Billed)
MORGAN MEMORIAL HOSPITAL	59	$45,532.00	0%
LANIER HEALTH SERVICES	77	$40,976.14	0%
MURPHY MEDICAL CENTER	20	$35,741.54	0%
CALHOUN MEMORIAL HOSPTIAL	99	$34,271.00	0%
ERLANGER NORTH HOSPITAL	12	$32,894.50	0%
COPPER BASIN MEDICAL CENTER	48	$32,748.61	0%
JASPER MEMORIAL HOSPITAL	47	$31,587.96	0%
ANGEL MEDICAL CENTER	30	$31,284.52	0%
LOUIS SMITH MEMORIAL HOSPITAL	15	$22,869.25	0%
WESLEY WOODS HOSPITAL	3	$9,475.00	0%
MEMORIAL NORTH PARK HOSPITAL	8	$8,781.08	0%
TOTAL	**137,164**	**$446,888,515.35**	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Month Received
Claims Pending as of November 1, 2007

Month and Year Initially Pended	Claim Count	Billed Amount
No Pend Date	1,948	$4,787,209.24
June 2006	31	$55,919.54
July 2006	550	$619,078.44
August 2006	866	$1,458,253.55
September 2006	689	$1,262,450.27
October 2006	951	$2,572,330.80
November 2006	1,147	$2,976,348.96
December 2006	1,353	$2,838,448.95
January 2007	1,923	$3,324,954.32
February 2007	1,695	$3,009,060.12
March 2007	1,956	$3,651,336.10
April 2007	1,150	$1,231,170.97
May 2007	1,154	$951,082.32
June 2007	860	$644,339.93
July 2007	7,868	$6,807,851.71
August 2007	9,934	$10,234,980.01
September 2007	77,053	$324,381,209.79
October 2007	24,600	$70,897,986.61
November 2007	1,436	$5,184,503.72
TOTAL	**137,164**	**$446,888,515.35**

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Reason Code
Claims Pending as of November 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pening Claims
Authorization / Medical Management Issue		**103,159**	**55.54%**
CLATH	Requires Authorization	70,846	38.14%
VSTER	Authorization Exceeds Day Visits	20,711	11.15%
MLATH	Multiple Auths Hold	10,090	5.43%
AUTNP	Authorization Not Found - Nonpar Only	873	0.47%
AUCST	Authorization Cost Exceeds	482	0.26%
AUHEL	Authorization Held	111	0.06%
MCLM1	Mchrl_Submitted Auth Does Not Match Provider_2	19	0.01%
AUTNW	Authorization Is New	7	0.00%
DN001	Prior Authorization Is Required But Was Not Obtained	6	0.00%
LIMAR	Limit Reached-Authorization Required	5	0.00%
UADMR	Under Administrative Review	3	0.00%
AUCLO	No Valid Authorization On File	2	0.00%
VSTHD	Days/Visits Billed Exceeds Authorized Days/Visits	2	0.00%
OUTAR	Claim Authorized Outside Of Service Date	1	0.00%
VSTEX	The Days/Visits/Units Billed On Claim Exceed The # Authd	1	0.00%
Claim Review		**82,578**	**44.46%**
HSSHD	HSS Hold - Check Processing Messages For Disposition Codes	23,066	12.42%
PODUP	Potential Duplicate	18,397	9.90%
HRM02	Rev/CPT Reversal Required	16,036	8.63%
DUPLM	Potential Duplicate Claim	5,629	3.03%
APCHD	APC Claim, Re-Eval APC Status And Manually Invoke Processing	5,576	3.00%
NDC	Claim Held For Entry Of NDC Number	5,111	2.75%
SPPRI	Special Pricing Required	2,674	1.44%
DOLLR	Security - Dollar Threshold Exceeded	1,026	0.55%
COB	Possible COB Claim	896	0.48%
HIGH$	High Dollar Threshold- Please Review	883	0.48%
WCPNP	Whole Claim Price - No Pricing	817	0.44%
COBOC	Undefined Other Carrier Code For COB	705	0.38%
CLMAN	Claim Requires Manual Intervention	679	0.37%
RV012	Req'd Refund; Awaiting Reimbursement From Provider	364	0.20%
SEGUP	Segment Update	219	0.12%
CLHLD	Claims On Hold, See Supervisor	163	0.09%
CL081	Transplant Case - Urn Rate Applicable	121	0.07%

Georgia Department of Community Health
Georgia Families
Exhibit 4f - WellCare - Suspended Non-CHOA Hospital Claims by Reason Code
Claims Pending as of November 1, 2007

Reason Code	Reason Description	Claim Count	Percent of All Pening Claims
LIMIT	Benefit Maximum Has Been Reached.	65	0.03%
DNM05	Pmnt Included In Apc Pricing Allowable For Another Svc/Proc	43	0.02%
EXDUC	Exact Duplicate Of Another Claim Or Service	21	0.01%
DNM02	Pmnt For Svc Is Not Allowed Under OPPS	16	0.01%
CTRSH	Held For Internal Research	14	0.01%
ADC30	Admission Chem Max Of 30 Days	12	0.01%
HRM07	HCRX/Implant: Manual Review Required	7	0.00%
DN016	This Is Not A Covered Procedure	4	0.00%
ACPAY	Due To Acpay Net Amt Vs. Claim Net Amt Discrepancy	4	0.00%
SACRE	Sacred Heart Claims Prior To 2/28/01	4	0.00%
DUPHD	Claim Tied To Duplicated Provider Id	3	0.00%
CL040	Anesthesia Calculation Needed	3	0.00%
DN075	Exact Duplicate Of Another Claim Or Service	3	0.00%
DN054	Invalid Procedure Code. Rebill With Valid Code	3	0.00%
EMGUI	E/M Services Guidelines High Level	2	0.00%
DN149	CPT Code Is Age Restricted, Manual Review	2	0.00%
RADMT	Radiology Material, Individual Review, Refer To Supervisor	1	0.00%
DN078	Pmnt For This Claim/Service Was Provided In A Previous Pmnt	1	0.00%
OB1	Delivery-Requires Manual Intervention	1	0.00%
MEMBR	Hold On Member	1	0.00%
MNFEE	Manually Assign Fee Allowable	1	0.00%
INELG	Member Not Eligible On The Date Of Service	1	0.00%
PDPHD	Incorrect Lob Selected	1	0.00%
DN025	No Contractual Fee Allowance	1	0.00%
MATHD	Maternity Hold	1	0.00%
NETAP	Pending Network Approval	1	0.00%
	TOTAL	**185,737**	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

A claim may be pended for more than one reason. Actual claim count is 137,164 claims.

Georgia Department of Community Health
Georgia Families
Exhibit 5a - AMERIGROUP - CHOA Hospital Claim Adjudication Analysis
Claims Paid or Denied between June 1, 2006 and August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Analysis assumes all adjudicated claims are "clean" and does not include suspended claims.

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	29,447	6,376	35,823	N/A
Number of Claims Manually Adjudicated	11,109	2,313	13,422	N/A
Number of Claims Auto Adjudicated	18,428	4,063	22,491	N/A
Percent of Claims Auto Adjudicated	**62.58%**	**63.72%**	**62.78%**	**N/A**
Number of Claims Adjudicated on Day of Receipt	12,185	2,452	14,637	$1,721
Number of Claims Adjudicated in 1-5 Days	11,670	2,373	14,043	$6,550
Number of Claims Adjudicated in 6-10 Days	3,189	952	4,141	$14,749
Number of Claims Adjudicated in 11-14 Days	794	376	1,170	$18,373
Percent of Claims Adjudicated within 14 Days	**94.54%**	**96.50%**	**94.89%**	**N/A**
Number of Claims Adjudicated in 15-30 Days	507	140	647	$13,385
Number of Claims Adjudicated in 31-60 Days	60	27	87	$29,153
Number of Claims Adjudicated in 61-90 Days	26	14	40	$33,241
Number of Claims Adjudicated in 91-120 Days	18	15	33	$17,856
Number of Claims Adjudicated in 121-180 Days	24	15	39	$18,832
Number of Claims Adjudicated in 181 + Days	974	12	986	$10,216

Georgia Department of Community Health
Georgia Families
Exhibit 5a - AMERIGROUP - CHOA Hospital Claim Denials by Reason
Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt - Claims Denied between June 1, 2006 through August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Reason Code	Denial Reason Description	Claim Count	Percent of Total
CDD/Y38	Definite Duplicate Claim	378	44.52%
NONE	NONE	64	7.54%
Y40/Y41	Deny preauth not obtained	62	7.30%
TF0	Submitted after plan filing limit	61	7.18%
CBP	Primary carrier info req	38	4.48%
003	Reduced allowable	34	4.00%
G41	RV code requires a valid procedure code	33	3.89%
N55	History Maximum Lifetime Occurrence	24	2.83%
N59	Incidental due to a procedure in history	18	2.12%
PFS/PSS	Disallowed = Diff of Billed vs Allowed	15	1.77%
	All Other	122	14.37%
	TOTAL	**849**	

Georgia Department of Community Health
Georgia Families
Exhibit 5b - AMERIGROUP - Non-CHOA Hospital Claim Adjudication Analysis
Claims Paid or Denied between December 1, 2006 and August 31, 2007
Analysis assumes all adjudicated claims are "clean" and does not include suspended claims.
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite claims

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	146,638	11,741	158,379	N/A
Number of Claims Manually Adjudicated	45,158	5,793	50,951	N/A
Number of Claims Auto Adjudicated	101,480	5,948	107,428	N/A
Percent of Claims Auto Adjudicated	**69.20%**	**50.66%**	**67.83%**	**N/A**
Number of Claims Adjudicated on Day of Receipt	65,971	3,756	69,727	$988
Number of Claims Adjudicated in 1-5 Days	63,736	4,993	68,729	$1,730
Number of Claims Adjudicated in 6-10 Days	8,463	1,297	9,760	$6,086
Number of Claims Adjudicated in 11-14 Days	3,292	621	3,913	$13,308
Percent of Claims Adjudicated within 14 Days	**96.47%**	**90.85%**	**96.05%**	**N/A**
Number of Claims Adjudicated in 15-30 Days	4,311	814	5,125	$23,377
Number of Claims Adjudicated in 31-60 Days	632	165	797	$16,235
Number of Claims Adjudicated in 61-90 Days	128	33	161	$5,113
Number of Claims Adjudicated in 91-120 Days	42	20	62	$1,643
Number of Claims Adjudicated in 121-180 Days	51	30	81	$1,450
Number of Claims Adjudicated in 181 + Days	12	12	24	$644

Georgia Department of Community Health
Georgia Families
Exhibit 5b - AMERIGROUP - Non-CHOA Hospital Claim Denials by Reason
Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt - Claims Denied between December 1, 2006 through August 31, 2007
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Reason Code	Denial Reason Description	Claim Count	Percent of Total
CDD	Definite Duplicate Claim	646	21.84%
NONE	NONE	383	12.95%
CBP	Primary carrier info req	247	8.35%
Y40	Deny preauth not obtained	179	6.05%
INC	Included in per diem/case rate	131	4.43%
N59	Incidental due to a procedure in history	130	4.39%
003	Reduced allowable	115	3.89%
Y41	Deny preauth not obtained	92	3.11%
PSS	Disallowed = Diff of Billed vs Allowed	92	3.11%
N01	Incidental to a current procedure	89	3.01%
	All Other	854	28.87%
	TOTAL	**2,958**	

Georgia Department of Community Health
Georgia Families
Exhibit 5c - Peach State Health Plan - CHOA Hospital Claim Adjudication Analysis
Claims Paid or Denied between June 1, 2006 and August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Analysis assumes all adjudicated claims are "clean" and does not include suspended claims.

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	57,823	11,473	69,296	N/A
Number of Claims Manually Adjudicated	4,760	1,826	6,586	N/A
Number of Claims Auto Adjudicated	53,063	9,647	62,710	N/A
Percent of Claims Auto Adjudicated	**91.77%**	**84.08%**	**90.50%**	**N/A**
Number of Claims Adjudicated on Day of Receipt	4,440	2,429	6,869	N/A
Number of Claims Adjudicated in 1-5 Days	40,420	6,721	47,141	N/A
Number of Claims Adjudicated in 6-10 Days	7,591	894	8,485	N/A
Number of Claims Adjudicated in 11-14 Days	1,443	244	1,687	N/A
Percent of Claims Adjudicated within 14 Days	**93.21%**	**89.67%**	**92.62%**	**N/A**
Number of Claims Adjudicated in 15-30 Days	844	235	1,079	$1,844
Number of Claims Adjudicated in 31-60 Days	755	83	838	$14,188
Number of Claims Adjudicated in 61-90 Days	255	49	304	$12,645
Number of Claims Adjudicated in 91-120 Days	470	331	801	$21,056
Number of Claims Adjudicated in 121-180 Days	990	238	1,228	$34,583
Number of Claims Adjudicated in 181 + Days	615	249	864	$12,391

Georgia Department of Community Health
Georgia Families
Exhibit 5c - Peach State Health Plan - CHOA Hospital Claim Denials by Reason
Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt - Claims Denied between June 1, 2006 through August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Reason Code	Denial Reason Description	Claim Count	Percent of Total
EX18	DENY: DUPLICATE CLAIM/SERVICE	637	36.32%
EX16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED	228	13.00%
EXN3	YOUR NPI IS NOT ON FILE/VALID OR YOU HAVE NOT BILLED WITH YOUR NPI	135	7.70%
EXL6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.	133	7.58%
EXA1	DENY: AUTHORIZATION NOT ON FILE	97	5.53%
EXDZ	DENY: SERVICE HAS EXCEEDED THE AUTHORIZED LIMIT	94	5.36%
EX29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED	76	4.33%
EX28	DENY: COVERAGE NOT IN EFFECT WHEN SERVICE PROVIDED	59	3.36%
EXMQ	DENY: MEMBER NAME/NUMBER/DATE OF BIRTH DO NOT MATCH,PLEASE RESUBMIT	46	2.62%
EXGM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K	38	2.17%
	All Other	211	12.03%
	TOTAL	**1,754**	

Georgia Department of Community Health
Georgia Families
Exhibit 5d - Peach State Health Plan - Non-CHOA Hospital Claim Adjudication Analysis
Claims Paid or Denied between December 1, 2006 and August 31, 2007
Analysis assumes all adjudicated claims are "clean" and does not include suspended claims.
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite claims

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	227,216	47,560	274,776	N/A
Number of Claims Manually Adjudicated	37,047	15,200	52,247	N/A
Number of Claims Auto Adjudicated	190,169	32,360	222,529	N/A
Percent of Claims Auto Adjudicated	**83.70%**	**68.04%**	**80.99%**	**N/A**
Number of Claims Adjudicated on Day of Receipt	0	0	0	N/A
Number of Claims Adjudicated in 1-5 Days	169,492	30,291	199,783	N/A
Number of Claims Adjudicated in 6-10 Days	33,555	9,979	43,534	N/A
Number of Claims Adjudicated in 11-14 Days	4,023	2,817	6,840	N/A
Percent of Claims Adjudicated within 14 Days	**91.13%**	**90.60%**	**91.04%**	**N/A**
Number of Claims Adjudicated in 15-30 Days	6,894	2,191	9,085	$18,453
Number of Claims Adjudicated in 31-60 Days	4,533	979	5,512	$106,951
Number of Claims Adjudicated in 61-90 Days	2,751	534	3,285	$113,828
Number of Claims Adjudicated in 91-120 Days	2,147	314	2,461	$53,709
Number of Claims Adjudicated in 121-180 Days	3,078	310	3,388	$95,548
Number of Claims Adjudicated in 181 + Days	743	145	888	$39,920

Georgia Department of Community Health
Georgia Families
Exhibit 5d - Peach State Health Plan - Non-CHOA Hospital Claim Denials by Reason
Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt - Claims Denied between December 1, 2006 through August 31, 2007
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Reason Code	Denial Reason Description	Claim Count	Percent of Total
EX18	DENY: DUPLICATE CLAIM/SERVICE	3,041	28.13%
EXN3	YOUR NPI IS NOT ON FILE/VALID OR YOU HAVE NOT BILLED WITH YOUR NPI	1,031	9.54%
EXBG	DENY: TYPE OF BILL MISSING OR INCORRECT ON CLAIM, PLEASE RE-SUBMIT	1,003	9.28%
EX46	DENY: THIS SERVICE IS NOT COVERED	756	6.99%
EX16	DENY: REVENUE CODE NOT REIMBURSABLE - CPT/HCPCS CODE REQUIRED	660	6.10%
EXL6	DENY: BILL PRIMARY INSURER 1ST. RESUBMIT WITH EOB.	598	5.53%
EX29	DENY: THE TIME LIMIT FOR FILING HAS EXPIRED	557	5.15%
EXGM	DENY: RESUBMIT W/ MEDICAID# OF INDIVIDUAL SERVICING PROVIDER IN BOX 24K	377	3.49%
EXA1	DENY: AUTHORIZATION NOT ON FILE	352	3.26%
EXMA	MEDICAID# MISSING OR NOT ON FILE, PLEASE CORRECT AND RESUBMIT	280	2.59%
	All Other	2,157	19.95%
	TOTAL	**10,812**	

Georgia Department of Community Health
Georgia Families
Exhibit 5e - WellCare - CHOA Hospital Claim Adjudication Analysis
Claims Paid or Denied between June 1, 2006 and August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Analysis assumes all adjudicated claims are "clean" and does not include suspended claims.

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	43,265	6,260	49,525	N/A
Number of Claims Manually Adjudicated	4,027	3,244	7,271	N/A
Number of Claims Auto Adjudicated	39,238	3,016	42,254	N/A
Percent of Claims Auto Adjudicated	**90.69%**	**48.18%**	**85.32%**	**N/A**
Number of Claims Adjudicated on Day of Receipt	5,490	1,198	6,688	N/A
Number of Claims Adjudicated in 1-5 Days	18,366	2,265	20,631	N/A
Number of Claims Adjudicated in 6-10 Days	16,146	2,011	18,157	N/A
Number of Claims Adjudicated in 11-14 Days	1,813	516	2,329	N/A
Percent of Claims Adjudicated within 14 Days	**96.65%**	**95.69%**	**96.53%**	**N/A**
Number of Claims Adjudicated in 15-30 Days	628	246	874	$0
Number of Claims Adjudicated in 31-60 Days	154	5	159	$0
Number of Claims Adjudicated in 61-90 Days	255	6	261	$0
Number of Claims Adjudicated in 91-120 Days	160	1	161	$0
Number of Claims Adjudicated in 121-180 Days	159	5	164	$0
Number of Claims Adjudicated in 181 + Days	94	7	101	$0

Georgia Department of Community Health
Georgia Families
Exhibit 5e - WellCare - CHOA Hospital Claim Denials by Reason
Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt - Claims Denied between June 1, 2006 through August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Reason Code	Denial Reason Description	Claim Count	Percent of Total
197	Payment adjusted for absence of precertification/ authorization.	391	41.33%
18	Duplicate claim/service.	291	30.76%
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	39	4.12%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	39	4.12%
109	Claim not covered by this payer/contractor. You must send the claim to the correct payer/contractor.	34	3.59%
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provider.	30	3.17%
198	Payment Adjusted for exceeding precertification/ authorization.	25	2.64%
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	22	2.33%
94	Processed in Excess of charges.	15	1.59%
15	Payment adjusted because the submitted authorization number is missing, invalid, or does not apply to the billed services or provide	10	1.06%
	All Other	50	5.29%
	TOTAL	**946**	

Georgia Department of Community Health
Georgia Families
Exhibit 5f - WellCare - Non-CHOA Hospital Claim Adjudication Analysis
Claims Paid or Denied between December 1, 2006 and August 31, 2007
Analysis assumes all adjudicated claims are "clean" and does not include suspended claims.
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite claims

	Claims Paid	Claims Denied	TOTAL	Interest Paid
Total Claims Adjudicated	397,235	79,826	477,061	N/A
Number of Claims Manually Adjudicated	30,924	52,657	83,581	N/A
Number of Claims Auto Adjudicated	366,311	27,169	393,480	N/A
Percent of Claims Auto Adjudicated	**92.22%**	**34.04%**	**82.48%**	**N/A**
Number of Claims Adjudicated on Day of Receipt	72,180	27,944	100,124	N/A
Number of Claims Adjudicated in 1-5 Days	206,736	36,886	243,622	N/A
Number of Claims Adjudicated in 6-10 Days	106,893	12,794	119,687	N/A
Number of Claims Adjudicated in 11-14 Days	6,756	1,276	8,032	N/A
Percent of Claims Adjudicated within 14 Days	**98.82%**	**98.84%**	**98.83%**	**N/A**
Number of Claims Adjudicated in 15-30 Days	2,551	671	3,222	$0
Number of Claims Adjudicated in 31-60 Days	735	75	810	$0
Number of Claims Adjudicated in 61-90 Days	464	145	609	$0
Number of Claims Adjudicated in 91-120 Days	201	13	214	$0
Number of Claims Adjudicated in 121-180 Days	347	10	357	$0
Number of Claims Adjudicated in 181 + Days	372	12	384	$0

Georgia Department of Community Health
Georgia Families
Exhibit 5f - WellCare - Non-CHOA Hospital Claim Denials by Reason
Top Ten Denial Reasons for Claims Denied Ten or More Days After Receipt - Claims Denied between December 1, 2006 through August 31, 2007
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Reason Code	Denial Reason Description	Claim Count	Percent of Total
197	Payment adjusted for absence of precertification/ authorization.	1,781	38.87%
18	Duplicate claim/service.	931	20.32%
97	Payment is included in the allowance for another service/procedure.	420	9.17%
45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.	313	6.83%
150	Payment adjusted because the payer deems the information submitted does not support this level of service.	270	5.89%
97	Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated	178	3.88%
B13	Previously paid. Payment for this claim/service may have been provided in a previous payment.	109	2.38%
A1	Claim denied charges	105	2.29%
22	Payment adjusted because this care may be covered by another payer per coordination of benefits.	69	1.51%
181	Payment adjusted because this procedure code was invalid on the date of service	59	1.29%
	All Other	347	7.57%
	TOTAL	**4,582**	

Georgia Department of Community Health
Georgia Families
Exhibit 6a - AMERIGROUP - CHOA Hospital Claims Activity by Date Incurred
June 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	June 2006	July 2006	August 2006	September 2006	October 2006	November 2006	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total
Children's Healthcare of Atlanta at Egleston	6/1/2006		15	1,442	1,235	1,188	956	1,112	1,136	1,330	1,190	1,167	1,256	1,318	1,164	981	860	983	17,318
Children's Healthcare of Atlanta at Scottish Rite	6/1/2006		15	2,159	1,466	1,428	1,266	1,442	1,479	1,434	1,834	1,446	1,685	1,476	1,215	1,189	1,113	1,159	21,791
				3,601	**2,701**	**2,616**	**2,222**	**2,554**	**2,615**	**2,764**	**3,024**	**2,613**	**2,941**	**2,794**	**2,379**	**2,170**	**1,973**	**2,142**	**39,109**

Claim counts include paid and denied claims based on date of service

Georgia Department of Community Health
Georgia Families
Exhibit 6b - AMERIGROUP - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
Barrow Regional Medical Ctr	9/1/2006		12	4	17	13	2	3	3	15	11	25	93	625%
Wellstar Windy Hill Hospital	6/1/2006		15	7	11	8	5	16	3	16	23	13	102	186%
Tanner Medical Center Carrollton	6/1/2006		15	116	132	102	71	108	59	133	138	171	1,030	147%
Athens Regional Medical Ctr	11/7/2006		10	782	866	580	265	733	282	1,071	1,115	1,127	6,821	144%
Piedmont Fayette Hospital	4/1/2006		17	149	137	180	71	159	74	180	218	214	1,382	144%
Northside Hospital	4/1/2006		17	249	252	240	122	268	135	320	315	355	2,256	143%
WellStar Paulding Hospital	6/1/2006		15	92	95	97	57	80	49	129	85	120	804	130%
Hamilton Medical Ctr	12/1/2006		9	472	542	261	136	564	344	588	563	604	4,074	128%
Walton Regional Medical Ctr	9/1/2006		12	11	7	20	13	12	8	13	43	14	141	127%
Newton Medical Ctr	6/1/2006		15	170	203	204	89	228	157	192	202	209	1,654	123%
Tanner Medical Center - Villa Rica	6/1/2006		15	131	123	118	84	125	61	113	110	150	1,015	115%
Memorial Health University Medical Ctr	9/1/2006		12	1,066	1,275	1,232	574	941	473	969	1,004	1,207	8,741	113%
Emory University Hospital	4/1/2006		17	80	88	70	28	88	39	93	72	88	646	110%
Emory Adventist Hospital	4/1/2006		17	50	59	76	32	53	37	75	66	54	502	108%
Jeff Davis Hospital	9/27/2006		12	63	71	95	45	62	37	37	48	67	525	106%
Wellstar Douglas Hospital	6/1/2006		15	214	217	193	150	202	101	211	215	226	1,729	106%
Effingham Hospital	9/1/2006		12	99	105	104	44	81	45	80	94	103	755	104%
Chatuge Regional Hospital	9/1/2006		12	25	29	21	4	26	11	25	25	26	192	104%
Grady Memorial Hospital	4/1/2006		17	1,071	1,177	1,010	527	1,015	614	973	1,070	1,109	8,566	104%
Jefferson Hospital	6/1/2006		15	127	121	155	56	113	68	115	130	128	1,013	101%
Piedmont Mountainside Hospital	4/1/2006		17	67	67	56	31	50	36	67	64	67	505	100%
Union General Hospital	9/9/2006		12	126	125	96	39	89	21	107	86	126	815	100%
Screven County Hospital	9/1/2006		12	63	46	39	3	54	2	55	42	62	366	98%
Wayne Memorial Hospital	9/1/2006		12	258	246	258	116	223	115	191	186	252	1,845	98%
Jasper Memorial Hospital	6/1/2006		15	30	28	33	12	18	12	18	13	29	193	97%
Emory Crawford Long Hospital	4/1/2006		17	291	291	229	77	282	123	323	310	277	2,203	95%
Southern Regional Medical Ctr	6/1/2006		15	705	600	591	323	577	419	620	639	669	5,143	95%
Gwinnett Hospital Systems	6/1/2006		15	583	607	481	241	568	308	550	516	552	4,406	95%
Henry Medical Center	4/1/2006		17	331	334	279	47	308	139	310	350	311	2,409	94%
McDuffie County Hospital	12/1/2006		9	160	211	167	83	176	70	144	125	149	1,285	93%
Liberty Regional Medical Ctr	9/14/2006		12	434	470	436	198	372	198	371	333	389	3,201	90%
Southeast Georgia Health System - Camden Campus	12/20/2006		9	177	164	172	102	178	95	134	119	158	1,299	89%
University Hospital	9/1/2006		12	846	1,009	810	201	727	297	712	778	749	6,129	89%
BJC Medical Center	9/6/2006		12	164	165	142	43	142	84	118	128	145	1,131	88%
Burke Medical Center	9/1/2006		12	220	201	211	91	183	128	157	167	193	1,551	88%
Redmond Regional Medical Ctr	9/1/2006		12	153	171	143	72	134	116	133	139	133	1,194	87%
Northside Hospital-Cherokee	4/1/2006		17	183	161	126	83	157	83	88	138	159	1,178	87%
Emanuel Medical Ctr	9/1/2006		12	124	113	136	61	94	6	87	91	105	817	85%
Rockdale Medical Center	6/1/2006		15	328	304	282	164	304	170	283	269	276	2,380	84%
Southeast Georgia Health System - Brunswick Campus	12/19/2006		9	530	542	467	222	500	252	440	360	434	3,747	82%

Georgia Department of Community Health
Georgia Families
Exhibit 6b - AMERIGROUP - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
Wellstar Cobb Hospital	6/1/2006		15	590	595	535	318	481	287	630	521	480	4,437	81%
Minnie G. Boswell Memorial Hospital	9/1/2006		12	91	92	60	18	37	5	37	42	74	456	81%
Habersham County Medical Ctr	6/21/2006		15	127	125	127	24	108	60	115	136	103	925	81%
Candler Hospital	9/1/2006		12	183	158	132	45	105	92	144	125	148	1,132	81%
Appling Healthcare System	9/25/2006		12	30	21	14	8	22	3	16	20	24	158	80%
Meadows Regional Medical Ctr	9/1/2006		12	310	344	350	142	288	119	235	263	246	2,297	79%
St Mary's Hospital	9/1/2006		12	398	362	363	158	331	154	292	285	311	2,654	78%
Evans Memorial Hospital	9/15/2006		12	104	104	93	36	97	40	83	109	80	746	77%
Piedmont Hospital	4/1/2006		17	39	39	41	12	42	16	32	36	30	287	77%
Washington County Regional Medical Ctr	4/1/2007		5	193	208	279	150	174	100	119	120	147	1,490	76%
Wellstar Kennestone Hospital	6/1/2006		15	657	602	515	263	525	228	544	460	500	4,294	76%
Jenkins County Hospital	9/1/2006		12	83	65	75	11	76	43	44	48	63	508	76%
Higgins General Hospital	6/1/2006		15	57	31	36	28	42	28	41	47	43	353	75%
Elbert Memorial Hospital	6/1/2006		15	81	56	76	42	57	30	63	54	61	520	75%
Northeast Georgia Medical Center	9/1/2006		12	1,215	1,106	1,013	506	993	459	847	861	900	7,900	74%
Satilla Regional Med Center	9/1/2006		12	477	391	432	227	283	82	308	242	345	2,787	72%
Fannin Regional Hospital	9/1/2006		12	112	110	83	57	85	61	85	73	80	746	71%
Hutcheson Medical Ctr	9/1/2006		12	433	496	324	179	307	173	332	349	309	2,902	71%
Northside Hospital-Forsyth	4/1/2006		17	132	99	88	75	106	76	76	92	91	835	69%
Cobb Memorial Hospital	9/1/2006		12	159	161	123	54	117	35	130	99	108	986	68%
Chestatee Regional Hospital	9/1/2006		12	175	163	138	58	141	97	118	95	115	1,100	66%
Charlton Memorial Hospital	9/1/2006		12	58	47	74	22	38	19	40	36	38	372	66%
Morgan Memorial Hospital	9/1/2006		12	58	71	74	25	25	1	32	33	38	357	66%
Hughes Spalding Children's Hospital	6/1/2006		15	1,053	884	1,014	485	893	555	712	655	686	6,937	65%
Murray Medical Center	12/1/2006		9	148	115	89	51	40	1	79	74	94	691	64%
North Georgia Medical Ctr	9/9/2006		12	330	297	115	65	139	91	132	133	206	1,508	62%
Wills Memorial Hospital	12/11/2006		9	89	82	85	26	59	39	54	68	55	557	62%
Stephens County Hospital	8/1/2006		13	405	290	262	63	272	106	231	224	250	2,103	62%
East Georgia Regional Medical Ctr	2/6/2007		7	164	181	102	49	76	37	103	103	99	914	60%
Anchor Hospital	9/1/2006		12	20	8	3	1	11	1	6	6	12	68	60%
St Joseph's Hospital	9/1/2006		12	5	10	9	2	5	2	5	3	3	44	60%
Piedmont Newnan Hospital	9/18/2006		12	77	85	71	0	3	0	46	55	44	381	57%
Emory Eastside Medical Center	9/1/2006		12	156	132	158	87	148	93	144	156	89	1,163	57%
Hart County Hospital	9/1/2006		12	183	152	117	53	101	56	78	94	103	937	56%
Tattnall Community Hospital	9/1/2006		12	89	64	63	51	47	1	48	33	50	446	56%
Polk Medical Center	9/1/2006		12	237	186	140	82	137	108	137	124	130	1,281	55%
Putnam General Hospital	9/1/2006		12	127	127	101	51	79	41	63	66	69	724	54%
Cartersville Medical Center	9/1/2006		12	201	160	159	76	186	124	191	170	106	1,373	53%
Candler County Hospital	9/1/2006		12	113	102	113	46	102	45	64	64	45	694	40%
St Joseph's Hospital of Atlanta	6/1/2006		15	12	19	5	0	4	4	19	8	4	75	33%

Georgia Department of Community Health
Georgia Families
Exhibit 6b - AMERIGROUP - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
Doctors Hospital of Augusta	9/1/2006		12	603	615	429	130	470	258	478	412	171	3,566	28%
Medical College of GA	9/1/2006		12	1,917	2,220	2,031	949	1,827	511	102	63	80	9,700	4%
Mountain Lakes Medical Ctr	11/10/2006		10	56	33	27	22	14	0	22	16	1	191	2%
Emory Johns Creek Hospital	1/18/2007		8	0	0	1	0	0	4	9	11	7	32	0%
Joan Glancy Memorial Hospital	6/1/2006		15	0	0	0	0	0	0	0	0	0	0	0%
Legacy Medical Center of Atlanta	11/3/2006		10	17	17	17	0	0	0	0	0	0	51	0%
Northeast Georgia Medical Ctr-Lanier Park	9/1/2006		12	0	1	0	0	0	0	0	0	0	1	0%
Shepherd Ctr	6/1/2006		15	2	4	0	1	1	0	1	1	0	10	0%
Wesley Woods Center of Emory University	4/1/2006		17	0	0	0	0	1	0	3	2	4	10	0%
				22,517	**22,612**	**20,089**	**9,332**	**19,108**	**9,559**	**17,346**	**17,087**	**17,887**	**155,537**	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Claim counts include paid and denied claims based on date of service

Georgia Department of Community Health
Georgia Families
Exhibit 6c - Peach State Health Plan - CHOA Hospital Claims Activity by Date Incurred
June 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	June 2006	July 2006	August 2006	September 2006	October 2006	November 2006	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total
CHILDRENS HLTH CARE OF ATL EGLESTON	06/01/06		15	2,334	3,252	3,112	2,154	2,363	2,506	2,691	2,369	2,147	2,521	2,047	2,072	1,657	1,497	1,883	34,605
SCOTTISH RITE CHILDRENS MED CTR	06/01/06		15	2,631	3,155	3,114	2,436	2,647	2,994	3,047	2,821	2,672	2,826	2,209	2,176	1,872	1,605	2,124	38,329
				4,965	**6,407**	**6,226**	**4,590**	**5,010**	**5,500**	**5,738**	**5,190**	**4,819**	**5,347**	**4,256**	**4,248**	**3,529**	**3,102**	**4,007**	**72,934**

Claim counts include paid and denied claims based on date of service

Georgia Department of Community Health
Georgia Families
Exhibit 6d - Peach State Health Plan - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
FLOYD MEDICAL CENTER	3/1/2007		6	1	0	0	4	10	11	20	18	25	89	2500%
PUTNAM GENERAL HOSPITAL	6/1/2006		15	2	4	7	8	5	5	3	7	9	50	450%
CHESTATEE REGIONAL HOSPITAL	10/10/2006		11	2	1	3	4	3	1	3	5	5	27	250%
NORTH GEORGIA MEDICAL CENTER	10/10/2006		11	2	16	13	13	13	11	5	3	5	81	250%
ROOSEVELT WARM SPRINGS INST FOR REHA	6/1/2006		15	6	6	7	12	9	10	16	42	13	121	217%
PHOEBE PUTNEY MEMORIAL HOSPITAL	6/1/2006		15	1,604	1,593	1,586	1,776	1,764	1,880	2,561	2,696	2,630	18,090	164%
MEDICAL COLLEGE OF GEORGIA HOSPITAL	3/1/2007		6	76	119	107	103	93	111	103	106	123	941	162%
EMORY UNIVERSITY HOSPITAL	6/1/2006		15	89	83	88	77	82	86	78	81	116	780	130%
HUGHSTON SPORTS MEDICINE HOSPITAL	6/1/2006		15	7	15	13	10	7	9	10	10	9	90	129%
COFFEE REGIONAL MEDICAL CTR	6/1/2006		15	6	6	14	8	17	22	7	15	7	102	117%
MEMORIAL HOSPITAL OF ADEL	9/1/2006		12	227	235	209	256	231	226	193	183	257	2,017	113%
COFFEE REGIONAL MEDICAL CTR	6/1/2006		15	366	502	437	455	497	463	505	409	412	4,046	113%
PHOEBE PUTNEY MEMORIAL HOSPITAL	6/1/2006		15	18	21	19	12	20	37	49	26	20	222	111%
DORMINY MEDICAL CENTER	6/1/2006		15	314	351	370	340	301	334	265	260	347	2,882	111%
CLINCH MEMORIAL HOSPITAL	9/1/2006		12	115	140	156	145	125	155	145	134	124	1,239	108%
BERRIEN COUNTY HOSPITAL	9/1/2006		12	111	110	129	168	124	130	94	96	119	1,081	107%
ARCHBOLD MEDICAL CENTER	9/1/2006		12	960	932	926	1,009	929	990	933	889	1,028	8,596	107%
FLINT RIVER COMMUNITY HOSP	6/1/2006		15	129	133	136	141	152	109	93	78	138	1,109	107%
DEKALB MEDICAL CENTER	6/1/2006		15	808	885	945	914	825	861	862	828	849	7,777	105%
SOUTH FULTON MEDICAL CTR TENET	6/1/2006		15	371	321	318	379	345	345	339	257	389	3,064	105%
MEDICAL CENTER OF CENTRAL GA	6/1/2006		15	1,857	2,175	2,366	2,386	2,250	2,229	1,760	1,415	1,893	18,331	102%
TAYLOR REGIONAL HOSPITAL	6/1/2006		15	353	395	364	342	328	292	241	257	359	2,931	102%
EVANS MEMORIAL HOSP INC	6/1/2006		15	1	3	2	1	0	0	1	1	1	10	100%
WALTON MEDICAL CENTER	6/1/2006		15	230	201	224	266	209	312	236	285	229	2,192	100%
PIEDMONT FAYETTE HOSPITAL	6/1/2006		15	257	245	300	326	239	260	236	268	245	2,376	95%
MEMORIAL HOSPITAL AND MANOR	9/1/2006		12	597	965	789	708	680	583	446	370	569	5,707	95%
WARM SPRINGS MEDICAL CENTER	6/1/2006		15	92	109	124	75	68	102	69	67	87	793	95%
ATLANTA MEDICAL CENTER-TENET	6/1/2006		15	447	422	408	445	380	415	343	305	422	3,587	94%
HENRY MEDICAL CENTER	6/1/2006		15	482	459	442	424	420	402	381	390	453	3,853	94%
OCONEE REGIONAL MEDICAL CENTER	6/1/2006		15	269	289	253	264	236	237	190	223	249	2,210	93%
REDMOND REGIONAL MEDICAL CENTER	6/1/2006		15	13	12	4	14	6	15	5	15	12	96	92%
IRWIN COUNTY HOSPITAL	6/1/2006		15	122	121	132	171	179	163	139	117	112	1,256	92%
SMITH NORTHVIEW HOSPITAL	6/1/2006		15	333	405	360	330	392	337	284	286	299	3,026	90%
SOUTH GEORGIA MEDICAL CENTER	9/1/2006		12	1,594	1,603	1,661	1,720	1,423	744	1,138	1,219	1,427	12,529	90%
NORTHSIDE HOSPITAL	6/1/2006		15	259	249	215	228	194	232	189	201	231	1,998	89%
SOUTHWEST GEORGIA REGIONAL	9/1/2006		12	216	262	307	296	173	278	224	209	192	2,157	89%
LOUIS SMITH MEMORIAL HOSPITAL	9/1/2006		12	120	92	97	115	115	117	77	88	106	927	88%
DONALSONVILLE HOSPITAL	9/1/2006		12	213	327	225	264	221	243	209	220	186	2,108	87%
STEWART WEBSTER HOSPITAL	6/1/2006		15	47	68	79	58	57	70	60	53	41	533	87%
MEDICAL CENTER INC	6/1/2006		15	777	900	708	823	725	726	540	615	667	6,481	86%

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Exhibit 6d - Peach State Health Plan - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
GRADY HEALTH SYSTEM	6/1/2006		15	1,657	1,674	1,444	1,494	1,389	1,501	1,174	1,074	1,379	12,786	83%
UPSON REGIONAL MEDICAL CENTER	6/1/2006		15	640	608	631	557	535	591	468	468	527	5,025	82%
BLECKLEY MEMORIAL HOSPITAL	6/1/2006		15	55	51	80	41	53	46	30	34	45	435	82%
PALMYRA MEDICAL CENTER	6/1/2006		15	429	385	380	377	367	379	282	256	351	3,206	82%
COLISEUM MEDICAL CENTER	6/1/2006		15	305	305	339	245	298	322	292	238	248	2,592	81%
EMORY CRAWFORD LONG HOSPITAL	6/1/2006		15	311	280	300	258	268	302	285	274	251	2,529	81%
COLQUITT REGIONAL HOSPITAL	9/1/2006		12	914	781	741	785	758	675	707	645	737	6,743	81%
GRADY GENERAL HOSPITAL	9/1/2006		12	278	265	288	278	266	271	201	190	221	2,258	79%
CALHOUN MEMORIAL HOSPITAL	9/1/2006		12	42	59	73	56	38	37	36	39	33	413	79%
JASPER MEMORIAL HOSPITAL AND REHAB	6/1/2006		15	65	81	63	58	44	52	47	33	51	494	78%
PHOEBE WORTH HOSPITAL	9/1/2006		12	243	231	309	375	323	291	206	280	190	2,448	78%
MONROE COUNTY HOSPITAL	6/1/2006		15	105	126	97	97	72	91	61	64	82	795	78%
DOCTORS HOSPITAL OF COLUMBUS	6/1/2006		15	328	285	306	352	339	317	296	278	254	2,755	77%
NORTH FULTON REGION HOSP TENET	6/1/2006		15	74	78	83	91	56	55	50	52	57	596	77%
DEKALB MEDICAL CENTER AT HILLANDALE	6/1/2006		15	776	706	727	753	626	604	544	468	589	5,793	76%
SPALDING REGIONAL HOSPITAL	6/1/2006		15	865	687	658	741	637	463	549	488	651	5,739	75%
ST FRANCIS HOSPITAL	1/1/2007		8	168	161	171	156	145	111	132	95	124	1,263	74%
MEMORIAL HEALTH UNIVERSITY MED CTR	3/1/2007		6	19	26	14	22	21	25	20	23	14	184	74%
SOUTHERN REGIONAL MEDICAL CENTER	6/1/2006		15	848	747	764	791	728	758	648	521	624	6,429	74%
ST MARYS HOSPITAL	3/1/2007		6	33	22	23	29	24	12	20	20	24	207	73%
FAIRVIEW PARK HOSPITAL	6/1/2006		15	585	531	538	491	479	471	426	373	425	4,319	73%
TANNER MEDICAL CENTER- VILLA RICA	6/1/2006		15	452	317	387	362	341	330	256	269	328	3,042	73%
DODGE COUNTY HOSP	6/1/2006		15	220	193	163	184	185	190	156	135	159	1,585	72%
WEST GEORGIA MEDICAL CTR	10/1/2006		11	1,470	1,738	1,323	895	860	929	913	872	1,023	10,023	70%
HIGGINS GENERAL HOSPITAL	6/1/2006		15	245	207	188	177	167	194	147	132	170	1,627	69%
NORTHSIDE HOSPITAL-FORSYTH	6/1/2006		15	141	86	90	100	94	113	63	57	95	839	67%
TANNER MEDICAL CENTER-CARROLLTON	7/1/2006		14	823	694	699	646	610	557	585	506	549	5,669	67%
JEFF DAVIS HOSPITAL	6/1/2006		15	12	8	8	10	5	14	11	10	8	86	67%
POLK MEDICAL CENTER	6/1/2006		15	9	8	4	10	4	6	11	10	6	68	67%
EARLY MEMORIAL HOSPITAL	9/1/2006		12	147	106	96	108	115	88	104	134	98	996	67%
GWINNETT MEDICAL CENTER	6/1/2006		15	1,702	1,522	1,497	1,524	1,374	1,282	1,051	1,005	1,132	12,089	67%
PIEDMONT MOUNTAINSIDE HOSPITAL	6/1/2006		15	152	136	142	132	96	98	68	89	100	1,013	66%
HUGHES SPALDING CHILDRENS HOSP	6/1/2006		15	1,605	1,475	1,553	1,591	1,363	1,261	1,118	845	1,055	11,866	66%
SYLVAN GROVE HOSPTIAL TENET	6/1/2006		15	125	97	97	83	82	83	63	62	82	774	66%
PIEDMONT HOSPITAL	6/1/2006		15	55	56	69	62	45	53	26	40	36	442	65%
CARTERSVILLE MEDICAL CENTER	6/1/2006		15	393	318	270	290	244	318	212	209	257	2,511	65%
EMORY EASTSIDE MEDICAL CENTER	6/1/2006		15	500	527	568	592	365	431	292	260	326	3,861	65%
EMORY ADVENTIST HOSP	6/1/2006		15	86	63	60	67	47	47	54	45	56	525	65%
NEWTON MEDICAL CENTER	6/1/2006		15	407	332	308	332	282	324	255	243	265	2,748	65%
CRISP REGIONAL HOSP	6/1/2006		15	359	408	332	401	490	482	251	219	229	3,171	64%

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December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
PEACH REGIONAL MEDICAL CENTER	6/1/2006		15	192	173	124	173	112	113	84	83	120	1,174	63%
SOUTHEAST ALABAMA MED CTR	2/1/2007		7	16	24	15	19	18	19	21	13	10	155	63%
BARROW REGIONAL MEDICAL CENTER	6/1/2006		15	157	146	136	130	110	130	82	86	97	1,074	62%
TAYLOR TELFAIR REGIONAL HOSPITAL	6/1/2006		15	39	49	59	39	35	40	28	28	24	341	62%
PERRY HOSPITAL	6/1/2006		15	84	65	58	54	50	55	54	30	48	498	57%
JOAN GLANCY MEMORIAL HOSPITAL	6/1/2006		15	104	89	132	117	103	74	75	31	59	784	57%
NORTHSIDE HOSPITAL- CHEROKEE	6/1/2006		15	334	225	233	244	217	223	172	181	187	2,016	56%
SUMTER REGIONAL HOSPITAL	9/1/2006		12	602	551	489	197	140	323	270	312	316	3,200	52%
ROCKDALE MEDICAL CENTER	6/1/2006		15	529	464	421	390	381	397	326	264	276	3,448	52%
BROOKS COUNTY HOSPITAL	9/1/2006		12	216	136	116	132	118	137	152	145	112	1,264	52%
MILLER COUNTY HOSPITAL	6/1/2006		15	197	225	163	191	218	157	127	81	101	1,460	51%
HOUSTON MEDICAL CENTER	6/1/2006		15	381	378	311	325	388	345	168	156	181	2,633	48%
ST JOSEPH HOSPITAL OF ATLANTA	6/1/2006		15	17	16	12	13	27	16	20	21	8	150	47%
WHEELER COUNTY HOSPITAL	6/1/2006		15	38	44	66	36	22	22	17	18	15	278	39%
GEORGE H LANIER MEMORIAL HOSPITAL	6/1/2006		15	21	13	18	17	21	16	21	12	8	147	38%
MITCHELL COUNTY HOSPITAL	9/1/2006		12	768	474	435	355	296	305	238	213	287	3,371	37%
SATILLA REGIONAL MEDICAL CTR	9/1/2006		12	17	10	10	17	12	17	13	16	6	118	35%
EMANUEL COUNTY HOSPITAL	2/1/2007		7	17	16	20	11	14	6	4	12	5	105	29%
BACON COUNTY HOSPITAL	6/1/2006		15	7	6	7	5	1	4	3	0	2	35	29%
SHEPHERD CENTER	6/1/2006		15	13	9	5	10	5	8	3	8	3	64	23%
GORDON HOSPITAL	6/1/2006		15	28	23	22	23	18	21	13	13	6	167	21%
TIFT GENERAL MEDICAL CENTER	9/1/2006		12	1,181	1,019	1,080	1,135	1,091	567	210	188	230	6,701	19%
COLISEUM NORTHSIDE HOSPITAL	6/1/2006		15	146	123	106	91	80	71	57	45	27	746	18%
WASHINGTON CNTY REGIONAL MED CENTER	6/1/2006		15	33	30	27	15	15	15	6	5	5	151	15%
CANDLER COUNTY HOSPITAL	6/1/2006		15	2	1	0	0	1	0	1	0	0	5	0%
CHARLTON MEMORIAL HOSPITAL	6/1/2006		15	0	0	1	0	0	0	1	0	0	2	0%
DECATUR HOSPITAL	6/1/2006		15	4	4	7	4	8	2	4	2	0	35	0%
DODGE COUNTY HOSP	6/1/2006		15	0	0	0	0	0	0	0	0	0	0	0%
EFFINGHAM HOSP & CARE CTR	6/1/2006		15	0	0	0	0	0	0	1	3	1	5	0%
HABERSHAM COUNTY MEDICAL CENTER	6/1/2006		15	0	0	0	2	2	1	1	0	0	6	0%
CHILDRENS HLTH CARE OF ATL EGLESTON	6/1/2006		15	0	0	0	0	0	0	0	0	0	0	0%
LIBERTY REGIONAL MEDICAL CENTER	6/1/2006		15	5	3	0	0	0	0	0	0	0	8	0%
PEACH REGIONAL MEDICAL CENTER	6/1/2006		15	0	0	0	0	0	0	0	0	0	0	0%
SCREVEN COUNTY HOSPITAL	6/1/2006		15	1	1	0	0	0	0	0	3	0	5	0%
WAYNE MEMORIAL HOSPITAL	6/1/2006		15	0	2	4	6	8	1	2	0	1	24	0%
WESLEY WOOD CTR OF EMORY UNIVERSITY	6/1/2006		15	1	0	0	0	0	0	1	0	0	2	0%
NORTH GEORGIA MEDICAL CENTER	10/1/2006		11	0	0	0	0	0	0	0	0	0	0	0%
PIEDMONT NEWNAN HOSPITAL	3/1/2007		6	0	0	0	143	129	112	101	117	86	688	0%
SPECIALTY LABO	5/1/2007		4	0	0	0	0	0	0	0	0	0	0	0%
ERLANGER MEDICAL CENTER	7/1/2007		2	0	0	0	0	0	0	1	2	0	3	0%

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Exhibit 6d - Peach State Health Plan - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
TCT CHILDRENS HOSPITAL	7/1/2007		2	1	3	0	0	0	0	3	4	0	11	0%
ELBERT MEMORIAL HOSPITAL	10/1/2007		0	0	0	0	0	0	0	0	0	0	0	0%
				36,287	**35,477**	**34,503**	**34,597**	**31,722**	**30,924**	**27,442**	**25,894**	**29,477**	**286,323**	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Claim counts include paid and denied claims based on date of service

Georgia Department of Community Health
Georgia Families
Exhibit 6e - WellCare - CHOA Hospital Claims Activity by Date Incurred
June 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	June 2006	July 2006	August 2006	September 2006	October 2006	November 2006	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total
CHOA AT EGLESTON	1/15/2007		8	1,434	1,266	1,349	1,450	1,550	1,902	1,547	1,450	1,568	1,611	1,368	1,415	1,125	1,109	1,153	21,297
CHOA AT SCOTTISH RITE	1/15/2007		8	2,227	1,603	1,792	1,950	2,324	2,928	2,315	2,078	2,035	2,116	1,722	1,722	1,495	1,448	1,665	29,420
				3,661	**2,869**	**3,141**	**3,400**	**3,874**	**4,830**	**3,862**	**3,528**	**3,603**	**3,727**	**3,090**	**3,137**	**2,620**	**2,557**	**2,818**	**50,717**

Claim counts include paid and denied claims based on date of service

Georgia Department of Community Health
Georgia Families
Exhibit 6f - WellCare - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
BERRIEN COUNTY HOSPITAL	9/1/2006		12	4	42	37	46	38	25	36	27	22	277	550%
WINDY HILL HOSPITAL	1/1/2007		8	15	24	15	96	59	30	20	83	23	365	153%
MEMORIAL HOSPITAL OF ADEL	9/1/2006		12	70	62	71	73	82	82	53	71	101	665	144%
JENKINS COUNTY HOSPITAL	5/1/2007		4	75	70	82	66	95	83	77	65	93	706	124%
OCONEE REG MEDICAL CENTER	7/1/2007		2	457	439	464	494	451	465	376	481	557	4,184	122%
ATLANTA MEDICAL CENTER	6/1/2006		15	337	296	335	365	358	361	364	349	410	3,175	122%
ROCKDALE MEDICAL CENTER	6/1/2006		15	362	415	406	386	373	385	330	411	439	3,507	121%
CLINCH MEMORIAL HOSPITAL	9/1/2006		12	52	57	79	98	93	114	77	97	63	730	121%
SATILLA REGIONAL MEDICAL CENTER	9/1/2006		12	632	694	686	618	643	652	599	666	758	5,948	120%
FAIRVIEW PARK HOSPITAL	2/1/2007		7	428	402	467	550	490	508	428	456	498	4,227	116%
NEWTON MEDICAL CENTER	1/2/2007		8	328	317	309	322	345	341	278	324	376	2,940	115%
FLINT RIVER HOSPITAL	6/1/2006		15	78	113	82	105	116	98	74	85	89	840	114%
EMORY CRAWFORD LONG HOSPITAL	9/1/2006		12	291	316	305	369	321	345	374	390	332	3,043	114%
NORTH FULTON REGIONAL HOSPITAL	6/1/2006		15	139	155	216	180	154	179	159	156	157	1,495	113%
HAMILTON MEDICAL CENTER	9/1/2006		12	843	856	732	769	825	847	722	853	941	7,388	112%
EFFINGHAM HOSPITAL	9/1/2006		12	173	152	147	161	143	164	153	144	192	1,429	111%
COFFEE REGIONAL MEDICAL CENTER	6/1/2006		15	605	640	615	595	577	619	518	536	665	5,370	110%
MEMORIAL HOSPITAL	9/1/2006		12	21	34	40	38	38	36	30	15	23	275	110%
SOUTH FULTON MEDICAL CENTER	6/1/2006		15	406	451	410	432	350	400	380	387	435	3,651	107%
CANDLER HOSPITAL	9/1/2006		12	940	982	1,038	963	888	970	951	956	1,003	8,691	107%
MOUNTAINSIDE MEDICAL CENTER	6/1/2006		15	215	180	185	208	205	212	184	169	227	1,785	106%
TAYLOR REGIONAL HOSPITAL	6/1/2006		15	315	313	311	292	267	287	247	251	332	2,615	105%
BJC MEDICAL CENTER	9/1/2006		12	155	184	156	159	138	130	110	140	162	1,334	105%
NORTHSIDE HOSPITAL	6/1/2006		15	469	428	420	493	431	437	425	483	489	4,075	104%
APPLING HEALTHCARE SYSTEM	9/1/2006		12	303	333	343	284	303	283	214	262	309	2,634	102%
PIEDMONT HOSPITAL	6/1/2006		15	53	56	34	56	43	55	54	44	54	449	102%
JEFF DAVIS HOSPITAL	6/1/2006		15	132	135	169	170	158	149	110	117	134	1,274	102%
WALTON REGIONAL MEDICAL CTR	6/1/2006		15	322	311	296	263	289	282	243	301	326	2,633	101%
WESLEY WOODS HOSPITAL	6/1/2006		15	1	1	1	0	1	0	0	0	1	5	100%
WAYNE MEMORIAL HOSPITAL	6/1/2006		15	377	430	388	355	352	327	307	350	375	3,261	99%
FAYETTE COMMUNITY HOSPITAL	6/1/2006		15	280	279	303	288	296	339	281	270	278	2,614	99%
HENRY MEDICAL CENTER	6/1/2006		15	496	404	511	469	483	516	420	414	492	4,205	99%
SE GEORGIA HEALTH SYSTEM-CAMDEN CAMPUS	9/1/2006		12	393	403	462	460	399	403	326	378	389	3,613	99%
EARLY MEMORIAL HOSPITAL	11/1/2006		10	92	87	123	82	88	101	74	85	91	823	99%
GRADY GENERAL HOSPITAL	11/1/2006		10	108	108	96	113	92	101	78	47	106	849	98%
MEDICAL COLLEGE OF GEORGIA	10/1/2007		0	2,044	2,124	2,133	2,222	1,958	1,985	1,769	1,861	1,996	18,092	98%
SOUTHERN REGIONAL MED CTR	7/1/2006		14	814	739	725	829	751	810	665	715	793	6,841	97%
MEDICAL CENTER OF CENTRAL GEORGIA	7/1/2007		2	2,602	2,813	2,710	2,616	2,513	2,553	2,234	2,345	2,527	22,913	97%
SMITH NORTHVIEW HOSPITAL	9/1/2006		12	98	69	77	71	91	83	61	98	95	743	97%
HABERSHAM COUNTY MEDICAL CENTER	9/1/2006		12	360	320	323	329	284	344	273	293	345	2,871	96%
NORTH GEORGIA MEDICAL CENTER	7/1/2007		2	349	283	238	270	290	228	194	292	334	2,478	96%
HIGGINS GENERAL HOSPITAL	3/1/2007		6	206	160	155	172	151	173	141	138	197	1,493	96%

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Exhibit 6f - WellCare - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
HUGHES SPALDING CHILDRENS HOSPITAL	6/2/2006		15	2,235	2,070	2,152	2,372	2,032	1,852	1,538	1,604	2,091	17,946	94%
EMORY UNIVERSITY HOSPITAL - MAIN	6/1/2006		15	154	131	127	125	87	166	150	131	144	1,215	94%
ATHENS REGIONAL MEDICAL CENTER	9/1/2006		12	1,258	1,230	1,167	1,103	1,193	1,060	881	1,006	1,171	10,069	93%
TIFT REGIONAL MEDICAL CENTER	9/1/2006		12	396	416	434	439	394	395	350	323	367	3,514	93%
SE GEORGIA HEALTH SYS-BRUNSWICK CAMPUS	9/1/2006		12	693	724	616	711	553	618	556	606	642	5,719	93%
MCDUFFIE REGIONAL MEDICAL CENTER	5/1/2007		4	149	142	168	123	152	149	123	121	138	1,265	93%
SYLVAN GROVE HOSPITAL	6/1/2006		15	121	103	87	94	114	131	86	92	112	940	93%
EAST GEORGIA REGIONAL MEDICAL CTR	1/1/2007		8	723	706	723	770	717	635	600	586	669	6,129	93%
THE MEDICAL CENTER	7/1/2007		2	1,144	1,067	992	955	899	1,053	884	930	1,052	8,976	92%
ELBERT MEMORIAL HOSPITAL	9/1/2006		12	147	162	130	155	146	119	105	123	135	1,222	92%
DOCTORS HOSPITAL	6/1/2006		15	459	467	474	503	429	469	420	378	421	4,020	92%
WILLS MEMORIAL HOSPITAL	9/1/2006		12	107	114	140	85	84	104	66	82	98	880	92%
DONALSONVILLE HOSPITAL	9/1/2006		12	148	145	125	142	117	134	120	139	135	1,205	91%
HUTCHESON MED CENTER	12/1/2006		9	566	616	560	554	482	487	440	494	516	4,715	91%
MEMORIAL HEALTH UNIVERSITY MED CTR	9/1/2006		12	1,675	1,693	1,883	1,891	1,663	1,657	1,317	1,423	1,526	14,728	91%
TATTNALL COMMUNITY HOSPITAL	2/1/2007		7	77	91	110	92	72	90	60	74	70	736	91%
CARTERSVILLE MEDICAL CENTER	6/1/2006		15	700	540	547	673	627	694	564	552	628	5,525	90%
MURRAY MEDICAL CENTER	9/1/2006		12	159	152	98	140	137	130	91	102	142	1,151	89%
EMANUEL MEDICAL CENTER	5/1/2007		4	283	290	346	298	257	274	205	245	251	2,449	89%
BARROW REGIONAL MEDICAL CTR	6/1/2006		15	245	246	221	235	216	269	209	201	216	2,058	88%
DODGE COUNTY HOSPITAL	9/1/2006		12	261	285	267	304	244	267	186	202	229	2,245	88%
UPSON REGIONAL MEDICAL CENTER	6/1/2006		15	530	473	461	482	512	519	381	389	465	4,212	88%
NORTHSIDE HOSPITAL CHEROKEE	6/1/2006		15	268	224	241	233	228	234	203	157	234	2,022	87%
COLISEUM NORTHSIDE HOSPITAL	6/1/2006		15	181	225	251	206	179	161	140	152	158	1,653	87%
NORTHSIDE HOSPITAL - FORSYTH	6/1/2006		15	267	255	249	244	236	314	227	220	233	2,245	87%
UNION GENERAL HOSPITAL	9/1/2006		12	245	246	233	212	205	194	161	199	213	1,908	87%
TANNER MEDICAL CENTER	3/1/2007		6	564	520	475	527	433	490	403	442	489	4,343	87%
TCT CHILDRENS HOSPITAL	8/1/2007		1	440	388	384	428	433	478	388	366	381	3,686	87%
BLECKLEY MEMORIAL HOSPITAL	6/1/2006		15	74	69	91	72	66	78	49	68	64	631	86%
WASHINGTON COUNTY REGIONAL MEDICAL CTR	9/1/2006		12	236	267	352	308	203	211	179	190	204	2,150	86%
MEADOWS REGIONAL MEDICAL CENTER	9/1/2006		12	584	562	547	513	477	441	455	460	504	4,543	86%
CRISP REGIONAL HOSPITAL	6/1/2006		15	576	566	512	610	530	518	497	504	497	4,810	86%
SPALDING REGIONAL MEDICAL CENTER	6/1/2006		15	545	451	454	423	403	463	370	467	468	4,044	86%
PARKRIDGE EAST HOSPITAL	9/1/2006		12	161	151	131	116	108	148	126	129	137	1,207	85%
SOUTH GEORGIA MEDICAL CENTER	9/1/2006		12	367	369	345	336	316	344	259	303	312	2,951	85%
COLQUITT REGIONAL MEDICAL CTR	9/1/2006		12	452	381	337	279	289	293	241	302	384	2,958	85%
PUTNAM GENERAL HOSPITAL	5/1/2007		4	159	168	123	146	146	136	119	118	135	1,250	85%
LIBERTY REGIONAL MEDICAL CENTER	9/1/2006		12	439	390	401	331	343	335	236	285	372	3,132	85%
HUGHSTON ORTHOPEDIC HOSPITAL	6/1/2006		15	13	12	13	5	6	5	11	13	11	89	85%
CHATUGE REGIONAL HOSPITAL INC	9/1/2006		12	58	49	34	50	43	56	36	38	49	413	84%
FANNIN REGIONAL HOSPITAL	9/1/2006		12	220	219	207	168	158	186	145	165	185	1,653	84%
LOUIS SMITH MEMORIAL HOSPITAL	9/1/2006		12	56	47	48	44	41	34	39	31	47	387	84%

Georgia Department of Community Health
Georgia Families
Exhibit 6f - WellCare - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
STEWART WEBSTER HOSPITAL	9/1/2006		12	97	108	97	123	100	113	55	89	81	863	84%
ANGEL MEDICAL CENTER	3/1/2007		6	12	16	8	16	11	12	14	16	10	115	83%
CHESTATEE REGIONAL HOSPITAL	9/1/2006		12	209	183	182	174	144	224	163	149	172	1,600	82%
IRWIN COUNTY HOSPITAL	9/1/2006		12	159	154	144	137	125	145	130	105	130	1,229	82%
EMORY EASTSIDE MEDICAL CTR	6/1/2006		15	406	380	343	381	352	348	272	268	331	3,081	82%
COBB MEMORIAL HOSPITAL	9/1/2006		12	220	181	199	200	201	183	155	176	179	1,694	81%
SCREVEN COUNTY HOSPITAL	9/1/2006		12	95	58	98	87	70	79	49	57	77	670	81%
BROOKS COUNTY HOSPITAL	11/1/2006		10	58	40	46	53	46	39	30	45	47	404	81%
AUGUSTA HOSPITAL	10/1/2006		11	207	53	190	214	148	170	142	143	167	1,434	81%
ST MARYS HEALTH CARE SYSTEM	9/1/2006		12	506	476	472	432	432	455	335	366	405	3,879	80%
JASPER MEMORIAL HOSPITAL	12/1/2006		9	65	61	63	46	43	52	39	44	52	465	80%
TANNER MEDICAL CTR - VILLA RICA	3/1/2007		6	480	340	355	348	390	364	352	396	383	3,408	80%
NORTHEAST GEORGIA MEDICAL CENTER	9/1/2006		12	1,664	1,440	1,504	1,426	1,196	1,241	1,153	1,183	1,312	12,119	79%
GORDON HOSPITAL	1/1/2007		8	449	362	306	399	322	417	357	381	353	3,346	79%
UNIVERSITY HOSPITAL	5/1/2007		4	994	979	873	809	762	781	709	771	777	7,455	78%
COPPER BASIN MEDICAL CENTER	2/1/2007		7	18	19	19	19	13	15	13	8	14	138	78%
DOUGLAS HOSPITAL	1/1/2007		8	527	464	422	421	443	469	346	376	409	3,877	78%
WELLSTAR COBB HOSPITAL	1/1/2007		8	1,425	1,222	1,278	1,290	1,165	1,243	971	975	1,105	10,674	78%
EVANS MEMORIAL HOSPITAL	9/1/2006		12	255	230	258	216	205	187	197	180	194	1,922	76%
WEST GEORGIA MEDICAL CENTER	10/1/2006		11	491	447	389	342	316	306	295	291	370	3,247	75%
JEFFERSON HOSPITAL	12/1/2006		9	171	219	142	168	161	169	96	130	128	1,384	75%
FLOYD MEDICAL CENTER	5/8/2007		4	1,904	1,437	1,315	1,346	537	1,101	1,118	1,124	1,420	11,302	75%
CANDLER COUNTY HOSPITAL	9/1/2006		12	99	95	108	89	72	73	63	48	73	720	74%
EMORY-ADVENTIST HOSPITAL	6/1/2006		15	121	110	87	96	65	98	79	69	89	814	74%
MONROE COUNTY HOSPITAL	6/1/2006		15	119	124	138	121	94	93	76	62	86	913	72%
JOHN D ARCHBOLD MEMORIAL HOSP	11/1/2006		10	115	99	93	92	71	102	59	71	83	785	72%
GRADY MEMORIAL HOSPITAL	7/1/2007		2	2,472	2,626	2,577	2,696	2,474	2,363	2,005	1,811	1,784	20,808	72%
GWINNETT MEDICAL CENTER	11/1/2006		10	1,879	1,683	1,692	1,712	1,483	1,502	1,321	1,305	1,355	13,932	72%
BURKE MEDICAL CENTER	4/1/2007		5	248	218	224	201	200	238	163	178	176	1,846	71%
DOCTORS HOSPITAL	6/1/2006		15	746	635	612	609	580	585	478	528	521	5,294	70%
MITCHELL COUNTY HOSPITAL	11/1/2006		10	145	128	112	89	109	95	70	76	101	925	70%
REDMOND REGIONAL MEDICAL CTR	6/1/2006		15	280	213	187	221	196	214	186	188	195	1,880	70%
COLISEUM MEDICAL CENTERS	6/1/2006		15	460	448	386	389	318	325	299	328	319	3,272	69%
ST JOSEPHS HOSPITAL	9/1/2006		12	168	134	164	151	143	138	133	134	116	1,281	69%
PAULDING HOSPITAL	1/1/2007		8	350	316	281	262	294	304	225	210	240	2,482	69%
PALMYRA MEDICAL CENTERS	6/1/2006		15	296	222	231	284	194	248	190	194	201	2,060	68%
SUMTER REGIONAL HOSPITAL	9/1/2006		12	500	466	433	195	204	303	264	306	334	3,005	67%
KENNESTONE HOSPITAL	1/1/2007		8	1,386	1,197	1,042	1,065	923	1,042	787	772	922	9,136	67%
MORGAN MEMORIAL HOSPITAL	9/1/2006		12	83	83	85	81	59	67	67	64	55	644	66%
POLK MEDICAL CENTER	6/1/2006		15	427	270	262	262	246	298	219	223	277	2,484	65%
PEACH REGIONAL MEDICAL CENTER	6/1/2006		15	316	273	235	206	207	191	161	187	204	1,980	65%
MINNIE G BOWSELL MEMORIAL HOSPITAL	9/1/2006		12	62	73	71	68	58	65	49	68	40	554	65%

Georgia Department of Community Health
Georgia Families
Exhibit 6f - WellCare - Non-CHOA Hospital Claims Activity by Date Incurred
December 1, 2006 through August 30, 2007

Provider Name	Effective Date	Term Date	Months Active in CMO as of 8/31/2007	December 2006	January 2007	February 2007	March 2007	April 2007	May 2007	June 2007	July 2007	August 2007	Total	August 2007 Claims Volume as % of December 2006 Claims Volume
WARM SPRINGS MEDICAL CENTER	6/1/2006		15	71	57	73	58	38	54	48	31	45	475	63%
MEMORIAL HOSPITAL AND MANOR	10/1/2007		0	175	136	151	218	229	135	120	129	108	1,401	62%
BACON COUNTY HOSPITAL	9/1/2006		12	283	353	238	219	186	178	169	189	166	1,981	59%
MOUNTAIN LAKES MEDICAL CENTER	9/1/2006		12	116	96	74	83	61	86	55	59	68	698	59%
SOUTHWEST GA REG MEDICAL	10/1/2007		0	59	41	56	65	38	56	45	31	34	425	58%
PERRY HOSPITAL	7/1/2007		2	299	241	209	190	227	180	126	163	172	1,807	58%
HART COUNTY HOSPITAL	9/1/2006		12	143	113	93	109	95	84	53	71	81	842	57%
STEPHENS COUNTY HOSPITAL	9/1/2006		12	680	505	496	424	369	404	336	347	385	3,946	57%
CHARLTON MEMORIAL HOSPITAL	9/1/2006		12	119	79	89	74	91	81	58	48	67	706	56%
DORMINY MEDICAL CENTER	9/1/2006		12	285	207	218	157	150	169	139	132	152	1,609	53%
MILLER COUNTY HOSPITAL	12/1/2006		9	158	140	147	173	193	134	85	104	84	1,218	53%
HOUSTON MEDICAL CENTER	8/1/2007		1	1,122	1,104	1,107	993	987	929	539	391	577	7,749	51%
WHEELER COUNTY HOSPITAL	6/1/2006		15	62	64	80	42	43	45	48	30	29	443	47%
TAYLOR-TELFAIR REGIONAL HOSPITAL	6/1/2006		15	76	88	69	81	99	82	70	43	31	639	41%
ERLANGER EAST HOSPITAL	7/1/2007		2	89	68	77	12	6	17	12	21	33	335	37%
PARKRIDGE MEDICAL CENTER	9/1/2006		12	9	12	6	6	8	12	4	8	3	68	33%
CALHOUN MEMORIAL HOSPTIAL	4/1/2007		5	84	59	55	26	41	43	35	44	24	411	29%
MURPHY MEDICAL CENTER	3/1/2007		6	8	6	11	8	1	5	2	2	2	45	25%
LANIER HEALTH SERVICES	9/1/2006		12	26	24	20	20	21	15	14	3	6	149	23%
NORTHEAST GEORGIA MED CTR-LANIER PARK	9/1/2006		12	10	10	5	16	12	10	10	6	2	81	20%
NORTHLAKE MEDICAL CENTER	6/1/2006		15	39	0	0	0	0	0	0	0	0	39	0%
NEWNAN HOSPITAL	6/1/2006		15	585	554	561	2	4	4	5	1	0	1,716	0%
PARKRIDGE VALLEY HOSPITAL	9/1/2006		12	0	0	0	1	0	0	0	1	0	2	0%
MEMORIAL NORTH PARK HOSPITAL	9/1/2006		12	0	0	1	2	1	0	2	4	3	13	0%
JOAN GLANCY HOSPITAL	10/1/2006		11	0	1	0	0	0	0	0	0	0	1	0%
BLEDSOE HOSPITAL	7/1/2007		2	0	0	0	0	0	0	0	0	0	0	0%
ERLANGER BARONESS HOSPITAL	7/1/2007		2	0	1	0	1	0	0	0	56	45	103	0%
ERLANGER NORTH HOSPITAL	8/1/2007		1	0	0	0	0	0	0	0	2	13	15	0%
				59,757	**56,340**	**55,510**	**54,940**	**50,064**	**52,073**	**43,885**	**46,028**	**50,941**	**469,538**	

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
Claim counts include paid and denied claims based on date of service

Georgia Department of Community Health
Georgia Families
Exhibit 7a - AMERIGROUP - CHOA Hospitals - Claims Denied for Member Eligibility Issues
Claims Paid or Denied between June 1, 2006 and August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
376	Incorrect subscriber ID	2	1	1	1
377	Incorrect subscriber ID	1	0	0	0
378	Incorrect subscriber ID	10	3	3	3
S13	All Enroll events are Future	2	0	10	0
ST	Termination	498	1	66	1
		513	**5**	**80**	**5**

Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

Georgia Department of Community Health
Georgia Families
Exhibit 7b - AMERIGROUP - Non-CHOA Hospitals - Claims Denied for Member Eligibility Issues
Claims Paid or Denied between December 1, 2006 and August 31, 2007
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
376	Incorrect subscriber ID	9	0	4	0
377	Incorrect subscriber ID	5	0	4	0
378	Incorrect subscriber ID	54	3	50	3
S13	All Enroll events are Future	11	3	9	3
ST	Termination	3,246	13	62	12
		3,325	**19**	**129**	**18**

Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

Georgia Department of Community Health
Georgia Families
Exhibit 7c - Peach State Health Plan - CHOA Hospitals - Claims Denied for Member Eligibility Issues
Claims Paid or Denied between June 1, 2006 and August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
EX26	Deny: Expenses Incurred Prior To Coverage	1	0	1	0
EX28	Deny: Coverage Not In Effect When Service Provided	1,431	27	90	24
EXMA	Medicaid# Missing Or Not On File, Please Correct And Resubmit	10	3	10	3
EXMQ	Deny: Member Name/Number/Date Of Birth Do Not Match,Please Resubmit	89	17	88	17
	TOTAL	**1,531**	**47**	**189**	**44**

Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

Georgia Department of Community Health
Georgia Families
Exhibit 7d - Peach State Health Plan - Non-CHOA Hospitals - Claims Denied for Member Eligibility Issues
Claims Paid or Denied between December 1, 2006 and August 31, 2007
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
EX26	Deny: Expenses Incurred Prior To Coverage	2	0	1	0
EX28	Deny: Coverage Not In Effect When Service Provided	6,534	136	333	127
EXMA	Medicaid# Missing Or Not On File, Please Correct And Resubmit	620	123	609	123
EXMQ	Deny: Member Name/Number/Date Of Birth Do Not Match,Please Resubmit	583	153	544	151
	TOTAL	**7,739**	**412**	**1,487**	**401**

Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

Georgia Department of Community Health
Georgia Families
Exhibit 7e - WellCare - CHOA Hospitals - Claims Denied for Member Eligibility Issues
Claims Paid or Denied between June 1, 2006 and August 31, 2007
Includes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
DN073	Member not Eligible on the date of service	3	2	3	2
DN095	Expenses incurred after coverage terminated	1	0	0	0
DN205	Incorrect member ID #	1	0	1	0
ELIGI	Loss Of Medicaid Eligibility	1	1	1	1
INELG	Member not Eligible on the date of service	6	2	2	1
	TOTAL	**12**	**5**	**7**	**4**

Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

Georgia Department of Community Health
Georgia Families
Exhibit 7f - WellCare - Non-CHOA Hospitals - Claims Denied for Member Eligibility Issues
Claims Paid or Denied between December 1, 2006 and August 31, 2007
Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite

Denial Code	Denial Reason	Number of Claims Denied	Number of claims Later Reprocessed	Number of Claims with Active Lock-in Span on Service Date	Reprocessed Claims related to Lock-in Spans
DN073	Member not Eligible on the date of service	6	1	3	1
DN205	Incorrect member ID #	269	80	267	79
INELG	Member not Eligible on the date of service	17	1	2	1
	TOTAL	**292**	**82**	**272**	**81**

Active lock-in span based upon member lock-in table provided by the Georgia Department of Community Health's fiscal agent.

Georgia Department of Community Health
Georgia Families
Exhibit 8a - AMERIGROUP - Comparison of Rates in Claims Payment System to Rates Specified in Contract Between CMO and Hospital

OUTPATIENT

Number of Outpatient Hospital Rates Loaded into CMOs Claims Payment System That Are *HIGHER* Than Rates Specified in Contract	0
Number of Outpatient Hospital Rates Loaded into CMOs Claims Payment System That Are *LOWER* Than Rates Specified in Contract	14
TOTAL Number of Outpatient Contracts Loaded At Rates Other Than Those Specified in Contract (Higher OR Lower)	14
TOTAL Number of Outpatient Claims Paid Between December 1, 2006 and August 31, 2007 Potentially Impacted by Rate Load Issues	27,985

INPATIENT

Number of Inpatient Hospital Rates Loaded into CMOs Claims Payment System That Are HIGHER Than Rates Specified in Contract	0
Number of Inpatient Hospital Rates Loaded into CMOs Claims Payment System That Are LOWER Than Rates Specified in Contract	1
TOTAL Number of Inpatient Contracts Loaded At Rates Other Than Those Specified in Contract (Higher OR Lower)	1
TOTAL Number of Inpatient Claims Paid Between December 1, 2006 and August 31, 2007 Potentially Impacted by Rate Load Issues	328

TOTAL

Total Number of Hospitals Contracted	83

Georgia Department of Community Health
Georgia Families
Exhibit 8b - Peach State Health Plan - Comparison of Rates in Claims Payment System to Rates Specified in Contract Between CMO and Hospital

OUTPATIENT

Number of Outpatient Hospital Rates Loaded into CMOs Claims Payment System That Are *HIGHER* Than Rates Specified in Contract	2
Number of Outpatient Hospital Rates Loaded into CMOs Claims Payment System That Are *LOWER* Than Rates Specified in Contract	3
TOTAL Number of Outpatient Contracts Loaded At Rates Other Than Those Specified in Contract (Higher OR Lower)	5
TOTAL Number of Outpatient Claims Paid Between December 1, 2006 and August 31, 2007 Potentially Impacted by Rate Load Issues	10,906

INPATIENT

Number of Inpatient Hospital Rates Loaded into CMOs Claims Payment System That Are HIGHER Than Rates Specified in Contract	3
Number of Inpatient Hospital Rates Loaded into CMOs Claims Payment System That Are LOWER Than Rates Specified in Contract	2
TOTAL Number of Inpatient Contracts Loaded At Rates Other Than Those Specified in Contract (Higher OR Lower)	5
TOTAL Number of Inpatient Claims Paid Between December 1, 2006 and August 31, 2007 Potentially Impacted by Rate Load Issues	1,368

TOTAL

Total Number of Hospitals Contracted	102

Georgia Department of Community Health
Georgia Families
Exhibit 8c - WellCare - Comparison of Rates in Claims Payment System to Rates Specified in Contract Between CMO and Hospital

OUTPATIENT

Number of Outpatient Hospital Rates Loaded into CMOs Claims Payment System That Are *HIGHER* Than Rates Specified in Contract	0
Number of Outpatient Hospital Rates Loaded into CMOs Claims Payment System That Are *LOWER* Than Rates Specified in Contract	0
TOTAL Number of Outpatient Contracts Loaded At Rates Other Than Those Specified in Contract (Higher OR Lower)	0
TOTAL Number of Outpatient Claims Paid Between December 1, 2006 and August 31, 2007 Potentially Impacted by Rate Load Issues	0

INPATIENT

Number of Inpatient Hospital Rates Loaded into CMOs Claims Payment System That Are HIGHER Than Rates Specified in Contract	0
Number of Inpatient Hospital Rates Loaded into CMOs Claims Payment System That Are LOWER Than Rates Specified in Contract	0
TOTAL Number of Inpatient Contracts Loaded At Rates Other Than Those Specified in Contract (Higher OR Lower)	0
TOTAL Number of Inpatient Claims Paid Between December 1, 2006 and August 31, 2007 Potentially Impacted by Rate Load Issues	0

TOTAL

Total Number of Hospitals Contracted	154

Georgia Department of Community Health
Georgia Families
Exhibit 9a - Analysis of Emergency Room Visits Paid at a Triage Rate - CHOA
Claims Paid or Denied between June 1, 2006 and August 31, 2007

AMERIGROUP				
Level	**Total Claims**	**Number of Claims Paid at Triage Rate**	**Number of Claims Paid at Emergency Rate**	**Percent of Total Claims Paid at Triage Rate**
99281	0	0	0	0.00%
99282	160	160	0	100.00%
99283	180	0	180	0.00%
99284	70	0	70	0.00%
99285	39	0	39	0.00%
	449	**160**	**289**	**35.63%**

Peach State Health Plan				
Level	**Total Claims**	**Number of Claims Paid at Triage Rate**	**Number of Claims Paid at Emergency Rate**	**Percent of Total Claims Paid at Triage Rate**
99281	27	11	16	40.74%
99282	4,976	1,563	3,413	31.41%
99283	7,490	1,749	5,741	23.35%
99284	2,568	437	2,131	17.02%
99285	2,262	252	2,010	11.14%
	17,323	**4,012**	**13,311**	**23.16%**

WellCare				
Level	**Total Claims**	**Number of Claims Paid at Triage Rate**	**Number of Claims Paid at Emergency Rate**	**Percent of Total Claims Paid at Triage Rate**
99281	12	8	4	66.67%
99282	931	637	294	68.42%
99283	7,229	5,547	1,682	76.73%
99284	2,261	1,242	1,019	54.93%
99285	403	177	226	43.92%
	10,836	**7,611**	**3,225**	**70.24%**

WellCare and AMERIGROUP figures exclude hospital claims that did not also have a corresponding ER Physician Claim

Georgia Department of Community Health
Georgia Families
Exhibit 9b - Analysis of Emergency Room Visits Paid at a Triage Rate - Non-CHOA Hospitals
Claims Paid or Denied between December 1, 2006 and August 31, 2007

AMERIGROUP				
Level	Total Claims	Number of Claims Paid at Triage Rate	Number of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate
99281	477	127	350	26.62%
99282	6,628	1,205	5,423	18.18%
99283	39,972	4,304	35,668	10.77%
99284	17,003	892	16,111	5.25%
99285	4,910	49	4,861	1.00%
	68,990	**6,577**	**62,413**	**9.53%**

Peach State Health Plan				
Level	Total Claims	Number of Claims Paid at Triage Rate	Number of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate
99281	15,514	5,990	9,524	38.61%
99282	49,372	14,487	34,885	29.34%
99283	90,899	10,932	79,967	12.03%
99284	29,776	1,898	27,878	6.37%
99285	8,502	260	8,242	3.06%
	194,063	**33,567**	**160,496**	**17.30%**

WellCare				
Level	Total Claims	Number of Claims Paid at Triage Rate	Number of Claims Paid at Emergency Rate	Percent of Total Claims Paid at Triage Rate
99281	1,904	1,045	859	54.88%
99282	18,571	9,043	9,528	48.69%
99283	105,163	41,204	63,959	39.18%
99284	41,996	12,981	29,015	30.91%
99285	9,164	2,172	6,992	23.70%
	176,798	**66,445**	**110,353**	**37.58%**

Excludes Children's Healthcare of Atlanta at Egleston and Children's Healthcare of Atlanta at Scottish Rite
WellCare and AMERIGROUP figures exclude hospital claims that did not also have a corresponding ER Physician Claim

Exhibit 10

Department of Community Health

Response to Myers and Stauffer's Hospital Claims Audit Report #2 and CMO Policies & Procedures Audit Report #3

Side-by-Side Comparison of Implementation Activities for Audit Findings and HB 1234

July 8, 2008

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
1	***Contract Loading and Provider Setup Timeliness and Accuracy Issues***					
	42% loaded in system prior to contract effective date. Of remaining, average of 52 days between effective date and loading date (1-357 days). Percentage of contracts entered after effective date ranged was 37% PSHP; 47% WC; and 95% AGP.	Contract establish requirement for the maximum time to load contract terms, and establish procedures to verify accuracy of provider setup. Recommend 30 days, with possible extension to 60 during implementation periods. Require CMOs to generate physical report of terms as loaded to be sent to provider for review. DCH monitor adequacy of	Not addressed	Not addressed	See Credentialing Section 4.8.15	• Add contractual requirements related to timeliness of provider loading. • Require CMO reports to hospitals and providers on details of loaded information. • Develop reports for monitoring timeliness and accuracy of loading.

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		networks, timeliness of loading and setup.				
2	***Credentialing Timeliness Issues***					
	The number of days to complete credentialing ranged from 34 (WC) – 108 days (PSHP). WC completed credentialing of 13% of hospital *after* effective date; for PSHP this was 48%; AGP data could not be evaluated.	Include requirements for timeliness of credentialing. DOI regulations require decision within 90 days of receipt of all information. DCH may want to consider timeframe of 30 days for hospital providers. With extension during implementation phases.	**4.8.14.1** At a minimum the Contractor shall require that each Provider be credentialed in accordance with State law. The Contractor may impose more stringent Credentialing criteria than the State requires.	Not addressed	**4.8.15.1** At a minimum, the Contractor shall require that each Provider be credentialed in accordance with State law. The Contractor may impose more stringent Credentialing criteria than the State requires. . The Contractor shall Credential all completed applications packets within 120 calendar days of receipt.	Revision to contract gives CMO more time to credential provider than DOI regulations. Revise to be at least equal to DOI (90 days); M&S recommendation is for 30 days.
3	***High Claim Denial Rate Related to Prior Authorization Issues***					
	The rate of denied	Recommend changes	**4.9.2.1**	Not addressed	**4.9.2.1 –**	• Require CMOs

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	claims ranged from 50% during initial implementation to 9-15% ongoing. 16% of denials related to PA issues. • 72 hr rule for readmissions, merging of claim and PA data • Confusion of services requiring PA • Add on services during procedure • Auth of specific procedure vs. family of codes • Data entry problems Interest payments were confirmed for claims initially denied, but later paid.	to PA policies: • Consider use of standard PA form • Provide electronic confirmation of relevant PA info. • Automated process to merge records impacted by 72 hr rule • Require CMOs to produce comprehensive list of all procedures requiring PA • Allow add on procedures with post review. • Require authorization of family of codes • Require acceptance of PA from other CMO when member changes plans	Requires the CMO to issue a provider handbook which describes: • Covered services • Prior Authorization, Pre-Certification, and Referral procedures; • Claims submission protocols and standards, including instructions and • all information necessary for a clean or complete Claim; • Payment policies **4.10.1.5.12** and **4.10.1.5.17** also require provide contracts to contain above information regarding covered services and billing and coding requirements. Does not specify level of detail to which this information must be		Unchanged **4.11.4.1 –** Adds requirement that CMOs honor pre-existing authorizations for treatment or medications given by DCH or another CMO for at least the first 30 days of new eligibility.	to provide detailed information to providers on specific procedures that require PA • Require electronic verification of PA details

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			provided. Does not address standard PA form, electronic verification of PA information, allowing add-on procedures, family of codes, or accepting other CMO authorization (this was adopted in policy).			
4	***High Claim Denial Rate Related to Coding Policies, Coding Inconsistencies, and Benefit Limits***					
	25% of denied claims related to coding policies, coding inconsistencies, or benefit limits.	• Require CMOs to update and publish lists of covered services, those that require PA, global fee period, benefit limitations, other restrictions, revenue code/proc code	**4.16.1.13** Requires CMOs to inform providers about the information required for processing of a "clean" claim. CMOs shall make claim coding and processing guidelines available to providers.	Not Addressed	Moved to **4.16.1.11 –** content unchanged	• Require CMOs to provided detailed information to providers on specific coding requirements for claim payment

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		combinations. • Provide ongoing training for providers • Collaborative training between CMOs/provider association focused on coding policies • Ongoing, periodic meetings with associations	CMOs shall notify providers of any changes to claim processing or coding guidelines 90 days prior to implementation.			
5	***Large Suspended Claims Volume that May Result From CMO's Definitions of Clean Claims***					
	Number of CHOA suspended claims ranged from 32 (AGP) to 16,000 (WC). *Some claims in suspense status since June 2006* (AGP) but most within prior 3 months. Suspension of claims and lack of interest	• Require CMOs to define criteria for a clean claim. • Flag and report on clean claims. DCH monitor performance • Identify providers with recurrent problems and target for	**4.16.1.9** Requires that clams suspended for additional information be either paid or denied within 30 calendar days of suspense. If required information not received by 30th day, notice must be sent to provider noting reason for denial and additional	**33-24-59.5 (f)** Requires the CMOs to use the same timeframes as DCH for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims.	**4.16.1.9 –** removed This requirement no longer directly addressed. However, it likely falls under **4.16.1.1** - which states that the CMO is required to follow the	• Verify DCH timeframes for claims remaining in suspense status.

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	payments may result form non-standard definition of clean claim.	training.	information needed to adjudicate the claim. **4.16.1.13** The CMO is required to inform providers of information required to submit a clean claim. The CMO must notify providers 90 days prior to implementing any changes to claims coding or processing guidelines.		same time frames as DCH for claim submission, processing, payment, denial, and adjudication. **4.16.1.13** changed to **4.16.1.11**, content the same.	
6	***Timely Filing Denials & Confusion***					
	Providers report several issues including: • Different requirements between FFS and each of CMOs • Some CMOs using admission date to determine timely filing • Retro-active denials that cannot be appealed	• Require CMOs to follow FFS timeframes • Require CMOs to use discharge date as date of service • Suspend timely filing edits during implementation periods.	**4.16.1.12** Allows CMO to deny payment if claim not submitted within 120 days of date of service; require CMO to deny if submitted more than 180 days from date of service. CMO shall override if provider has evidence they erroneously filed with another CMO or the state within 120 days.	**33-24-59.5 (f)** Requires the CMOs to use the same timeframes as DCH for submission, processing, payment, denial, adjudication, and appeal of Medicaid claims.	**4.16.1.12 -** removed, replaced by section **4.16.1.1 -** which states that the CMO is required to follow the same time frames as DCH for claim submission, processing, payment, denial, and adjudication.	
7	***Apparently Improper Claim Denials for***					

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	Members That Appear to Have Been Eligible for CMO Coverage					
	Approximately 5% of claim denials relate to member eligibility. In many of these, system indicated member locked-in to CMO on date of service.	• Increase frequency of eligibility file transfers – recommend daily file transfer. • Require CMOs to identify discrepancies between their enrollment files and fiscal agent lock-in files.	Not addressed	**33-21-A-6(a)** Requires CMOs to pay for care to newborn, born to the mother that is covered under their plan. **33-21A-9 (a)** Requires payment to provider based on eligibility information, if provider documents that they verified eligibility within 72 hours of service, even if this eligibility later turns out to be incorrect. **33-21A-9 (b)** Allows provider	**4.16.1.9** Requires CMO to pay for services regardless of eligibility, if provider can document that they verified eligibility with that CMO within 72 hours of service. **4.16.1.10** Prohibits CMO for denying claims for timely filing or out-of-network status, when due to incorrect eligibility information.	• Determine whether more frequent eligibility file transfers would improve eligibility data • Develop central site for verification of all eligibility data • Investigate scenarios where CMOs denying for eligibility where member is locked-in to their CMO; address any systemic issues.

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
				to re-bill correct payer without penalty for timely filing, if initial eligibility information is incorrect.		
8	***Several Claims Payment Components and CMO Performance Indicators May Require Additional Monitoring for Contract Compliance***					
	Findings suggest additional monitoring may be necessary.	Financial Indicators: • Medical loss ratio • Administrative loss ratio • Current ratio • Days cash on hand • Cash to claims payable • Days in claims payable • Medicaid profit margin	Provider Network • Providers by specialty • Voluntary terminations The above reports are received and monitored monthly by DCH staff. See Section 4.8 Provider Network	Not Addressed		

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		Claim Indicators • Suspended claim volume • Denial claim volume • Interest payments • Claims paid at emergency and triage rates • ER appeal and overturn rates • Adjudication statistics • PA approval/denial rates Provider Network • Providers by specialty • Voluntary terminations • Contract loading timeliness • Credentialing timeliness • Member plan changes				
9	*Emergency Room*					

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	Coverage and Reimbursement Issues					
	CMOs utilize different methodologies to define and determine reimbursement of emergency medical conditions. 2 of 3 CMOs pay significant number of claims (99283-9985) at triage rate, but one eventually pays emergency rate on reconsideration. 2 of 3 CMOs do not consider time of day, day of week, or age of patient in making determination.	• Require CMOs to use standardized approach for reimbursement. Could base on CPT or diagnosis code. If diagnosis based, DCH should provide minimum list of presumed conditions. • Require CMOs to evaluate policies and modify based on reconsideration and overturn rates. • DCH evaluate and update list of presumed diagnoses on annual basis.	**4.6.1** States that emergency medical condition cannot be defined by a list of diagnoses or symptoms. Requires coverage based on prudent layperson standard. Must base on symptoms at time of presentation. Cannot deny retroactively deny if condition later determined to not be true emergency. If a representative of the CMO instructs the member to seek emergency services they shall be covered regardless of whether they meet prudent layperson standard.	**33-21A-4** In processes claims for emergency services, the CMO shall consider age of patient, time and day of week, severity of presenting symptoms, initial and final diagnosis, any other criteria prescribed by DCH.	No changes	• Require CMOs to submit specific guidelines for processing claims, review that complaint with HB 1234 requirements. • Require monthly reports on percentage of ER claims paying at emergency vs. triage rate • Conduct periodic audits on sample of claims paying at triage rate
10	*Claim Reprocessing for Known Claim Issues*					
	Some CMOs do not	Require CMOs to	(See section 4.16.1.12)	Not addressed	No change made	Implement M& S

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	routinely reprocess claims after making retroactive system changes, such as rate changes.	reprocess claims for known issues following system corrections or retroactive rate changes.	The Contractor shall assume all costs associated with Claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's span of control.			recommendation.

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
1	**CMO accreditation and notification requirements**					
	DCH contract does not mandate retention of accreditation, or notification of DCH in the event of any findings of deficiencies, or loss of accreditation.	• Require accreditation with one specific agency (NCQA) • Require notification of loss of accreditation within 15 days • Report any deficiencies found within 30 days • Require corrective action plan to address deficiencies within 60 days.	Not addressed	Not addressed	Not addressed	Include recommendations in future contract revisions.
2	**Comprehensive Managed Care Resources for Providers**					
	Virginia DMAS publishes annual Managed Care Resource Guide for providers that has summary of programs,	Publish annual resource guide for providers that includes key staff, PA processes at each plan,	Not Addressed	Not Addressed	Not Addressed	

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	staff, PA requirements, etc.	and other relevant information.				
3	**Emergency Medical Condition Definition Listed in Model Contract Contains an Inaccuracy**					
	Section 4.6.1.2.6 has error and states: "With respect to a pregnant woman having contractions: (i) that there is adequate time to effect a safe transfer to another hospital before delivery, or…" Per CFR should state "**in**adequate"	Change language to be consistent with CFR	Not Addressed	Not Addressed	Not Addressed	Correct language in current contract revision.
4	**CMOs Utilize Different Methodologies to Process Emergency Room Claims**					
	Same as Recommendation #9, *Emergency Room Coverage and Reimbursement Issues*, from Report #2.					
5	**Lack of Uniformity of Prior Authorization Processes**					

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	Hospitals noted a number of issues related to submission of prior authorization requests. MI uses a standard PA and standard credentialing form across all MCOs; FL is considering the use of a standard PA form. Currently each GA CMO has its own PA process.	• Require CMOs to collaboratively develop and utilize common PA form. • Provide electronic confirmation of authorization that includes all relevant information regarding the request. • Maintain comprehensive list of all services that require PA. • CMOs designate specific staff knowledgeable of PA process to communicate with providers • Require CMOs to conduct training for hospitals on PA requirements • Require payment of medically	**4.9.2.1** Requires the CMO to issue a provider handbook which describes: • Covered services • Prior Authorization, Pre-Certification, and Referral procedures; • Claims submission protocols and standards, including instructions and • all information necessary for a clean or complete Claim; • Payment policies **4.10.1.5.12** and	Not addressed by HB 1234. SB 507 requires DCH to implement consistent requirements, paperwork, and procedures for utilization review and prior approval of therapy services for children. SB 507 also requires that prior approval for services shall be for general areas of treatment or ranges of specific treatments or processing codes.	**4.9.2.1 –** Unchanged **4.11.4.1 –** Adds requirement that CMOs honor pre-existing authorizations for treatment or medications given by DCH or another CMO for at least the first 30 days of new eligibility.	• Require CMOs to provide detailed information to providers on specific procedures that require PA • Require electronic verification of PA details

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		necessary add-on procedures. Verification through post payment review. • Require authorization of family of codes for similar procedures • Require automated processes to merge records and authorizations when 72 hr rule applied. • Require acceptance of PA from another CMO when eligibility changes.	**4.10.1.5.17** also require provide contracts to contain above information regarding covered services and billing and coding requirements. Does not specify level of detail to which this information must be provided. Does not address standard PA form, electronic verification of PA information, allowing add-on procedures, family of codes, or accepting other CMO authorization (this was adopted in policy).			

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
6	**Recoupment Process Not Adequately Addressed in DCH Model Contract**					
	Provider feedback indicates that this is an issue. One state requires health plans to notify the state prior to recoupment.	• Include time-limit for recoupment • Require that CMO contracts and policies address recoupment process, provider rights, and that notice provides sufficient detail. • Address appeal rights related to recoupments in model contract.	Not addressed	If a provider has verified member eligibility through web portal CMO cannot recoup payment for members later determined to not be covered, if the service occurred within 72 hours of verification.	Contains same provision as HB 1234	Consider adding requirements to address recoupment process, provider rights, notice, and timeframes in CMO provider contracts.
7	**Providers Require Access to Explanation of Payment Disposition Codes**					
	Hospital providers indicate that they could not understand payment disposition codes, due to	• Require CMOs to provide payment disposition codes on website or	Not Addressed	Not Addressed	Not Addressed	

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
	insufficient information, or lack of explanation of benefit codes.	provider manual • Add information to provider resource manual • Require that each denied claim include detailed explanation.				
8	**Confusion Regarding the Provider Appeal Process**					
	There is considerable variation among CMOs regarding appeal processes.	• DCH add NCQA definitions regarding appeals to improve standardization • Require each CMO to permit appeals in accordance with contract • Add requirements to ensure timely and fair outside appeal process, and to consolidate appeals. • Require that CMOs provide complaint process	Current contract has specific requirements (4.14) related to both internal and external appeals that are mandated by CFR	• Requires CMO to allow provider to consolidate complaints or appeals relating to similar issues • Allows providers to select administrative review or binding arbitration.	Incorporates requirements of HB 1234 – 4.9.7.2 – Allow providers to consolidate complaints or appeals of multiple claims 4.9.7.3 – Allows provider that has exhausted internal appeal process to seek binding arbitration	

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
		with DCH.				
9	**DCH Model Contract Does Not Address the Date That Initiates the Start of Filing Time Limit Calculation**					
	DCH Contract does not specify whether admission or discharge date shall be used for calculating the claim filing time limit.	• DCH add requirement to include discharge date as criteria for filing time limit calculations.	Not addressed	DCH must require CMOs to utilize the same timeframes and deadlines for Medicaid claims as DCH uses for claims it pays directly.	Not addressed	
10	**Inconsistent Definition of Emergency Medical Services in CMO Contracts**					
	Each CMO is using a different definition of "Emergency Medical Services" in their contracts, which differs from the definition in the DCH CMO contract.	Require each CMO to use the same definition as in the DCH CMO model contract.	**Emergency Medical Condition:** A medical Condition manifesting itself by acute symptoms of sufficient severity (including severe	In processing claims for emergency care, a CMO must consider the age of the patient, the time and day of the week the patient presented for	No changes	

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined	services, the severity and nature of the symptoms, the patient's initial and final diagnosis, and any other criteria prescribed by DCH.		

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			on the basis of lists of diagnoses or symptoms.			
11	**Lack of Direction as to How to Apply the "72-Hour Rule"**					
	DCH model contract does not contain language regarding application of this reimbursement policy.	• Modify the model contract to include language regarding utilization of 72-hour rule, consistent with DCH FFS policy • Require CMOs to develop processes to properly merge updated authorization records when 72 hour rule is applied	Not Addressed	Not Addressed	Not Addressed	Address processes for application of 72 hour rule through DCH CMO policy manual.
12	Model Contract Provides Limited Information Regarding the Handling of Third Party Liability Claims	Consider adding requirements regarding the handling of third party liability claims.	8.4.2.1 - The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier...	Not Addressed	No Changes	

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			8.4.2.3 - The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services the Contractor shall ensure that services are provided without regard to insurance payment issues and must			

	M & S Finding	M& S Recommendations	Current Contract	HB 1234	New CMO Contract	Additional Recommendations
			provide the service first.			
13	**Innovative Incentive Plan Found in Comparison State**					
	Indiana uses 3 tiered approach of state incentive to MCO, who must reinvest at least 50% in physician and/or member incentive	DCH may wish to develop incentive plan for CMO, providers, and members.	7.4 - Allows for payment of performance incentives to CMOs for Health Check screening; blood lead screening; dental visits; newborn enrollment; and EPSDT tracking	Not Addressed	No Changes	

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
The initial Myers and Stauffer claims analyses appear to indicate that many hospital contracts were entered after the contract effective date.	Clarify whether this problem only related to the implementation process? Describe the steps have been (or were) taken to ensure that new contracts and/or providers are loaded prior to the effective date of the contract. Describe the process for monitoring contract loading to ensure that contracts are loaded prior to their effective date.	The concern regarding loading providers after the go-live date is a valid concern. Some reasons for this included: Providers submitted their contract after the go-live date but we agreed to back-date (for providers satisfaction reasons), providers were not through the credentialing process (i.e. missing data elements) so we held on loading the contract until we had all pertinent information and then backdated the effective date (to process claims), and we because most hospitals responded at go-live time and not prior, we had over 100 hospitals to load at the same time. Providers were given deadlines for the contract at least 30-90 days prior to go-live, but most waited until the week of go-live (or after) to submit their signed contracts. - For provider loading, the AGP process is to accept the credentialing application and contract from the providers. We take 30-45 days to credential/load the hospitals and then place the effective date in our system showing the date the contract was

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
		signed by the provider, or the date specifically listed as the effective date in the contract. In most cases, this would mean that the effective date will show a date prior to the loading of the contract. We notify providers when their contract is loaded and an orientation is performed. In the future you would see similar results related to contracts being loaded after the effective date since we do not push the effective date out until after the contract is loaded. We use the effective date as the date negotiated in the contract or the date the provider signed. In addition, we cannot finalize the loading process until the provider is through the credentialing process and credentialing committee approval (30-45 day process). Currently, our average turnaround time to load a hospital contract is approximately 30-40 days from receipt.
System corrections do not appear to automatically be applied to previously processed claims.	Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy	Please provide examples as to what is being referenced. For example, if the Interim Outpatient

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
	changes, eligibility updates or provider contracts loaded after the effective date).Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy changes, eligibility updates or provider contracts loaded after the effective date). • What steps are taken to ensure any previously submitted claims are reprocessed/adjusted? • Are all claims affected by the issue reprocessed/adjusted or only those claims submitted by the provider who brought the issue to your attention? • If you only reprocess/adjust the claims for the provider that brought the issue to your attention, please explain the rationale for this policy.	Rate (IOR) is changed by the state then AGP will make the updates but the changes are made prospectively and do not necessarily drive the requirement for reprocessing of claims. This is in compliance with AGP provider contracts • Per contracts with providers AGP will update the fee schedule no more than 90 days from receipt of notice of final changes or on the effective date of such changes, whichever is later. Fee Schedule changes will be applied on a prospective basis. If a contract has approval for a Non Standard Effective date (NSED) and was approved as such, then once the contract is loaded a claims report would be pulled and claims reprocessed to pay at the contracted rate based on the effective date in the NSED. NSED require approval by the COO or CEO of a Health Plan. If claims did not pay according to contract and a root cause issue is discovered then a complete claim report is pulled to determine all claims that would need to be reprocessed. Typically this is a result of a provider supplying a few claims as

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
		examples, the root cause is discovered, corrected and the above is completed to ensure all impacted claims are reprocessed in a claims project via the AGP CAMP process. If examples can be provided, we will review to determine if the claims were paid according to contract terms or if an error exist.
Interest payments do not appear to be applied to claims that are reprocessed to adjust for system or processing error.	Describe your policy for paying interest when claims are reprocessed/adjusted after a reference file or system update (e.g. corrected authorization, corrected file rate, delayed provider entry, or system logic change). • Is interest automatically paid to the provider retroactively to the date of original submission? • If you do not pay interest in these instances, please provide the rationale for not paying interest in these cases.	Interest Payments can not be seen with in the claims processing screen of a claim. You would have to transfer into the payment detail or pull an EOP to see the interest applied to a claim. If a claim is reprocessed for example waiving Timely Filing as the provider was at fault for the TFO submission then interest would not be applied to the claim if AGP agrees to pay and over ride TFO denials. To validate whether the M&S area of concern is correct, we will need claim examples from M&S to determine if interest was paid appropriately.
The initial Myers and Stauffer claims analyses appear to indicate that a	Please provide your analysis of the reasons/issues that are leading to these	AGP would need examples of claims from M&S to respond accurately and

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
significant portion of suspended claims and denied claims are related to authorization issues.	types of denials. Describe the steps or corrective actions that are being taken to address these issues.	completely to this statement. If a provider did not obtain an authorization and it was a service that required an authorization, it would be appropriate to deny or suspend a claim for review. If during the review we are unable to find an authorization in our system, the claim would be denied for no pre-authorization.
The initial Myers and Stauffer claims analyses appear to have identified claims denials that indicate the member was not eligible on the date of service. However, after reviewing the data from the fiscal agent contractor (ACS), it appears that these members were determined by DCH to be eligible on the date of service (i.e., a member included in the ACS lock-in file for which the CMO received a capitation payment).	Describe your policy and process for handling eligibility updates. Specifically indicate your reconciliation process for identifying and updating previously denied claims.	AGP would need examples of claims denied for eligibility reasons to respond accurately and completely to this statement. This information is also needed to identify the applicable policy and procedure.
It appears from the Myers and Stauffer claims analyses and provider input that monies previously paid under the merged member have, at times, been recouped with a notice indicating the member as not active. These claims often appear to have been denied for timely filing when resubmitted under the new member number.	Describe your process for handling merged member records. Is the claim history and authorization history transferred to the new member number? What steps have been taken to alleviate this issue?	AGP would need examples of claims to respond accurately and completely to this statement.

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
Provider complaints regarding ability to submit prior authorization data on-line, along with inability to obtain confirmation of authorization or status of request.	Please confirm that online access to prior authorization (PA) information is available to all providers and that they are able to receive PA status information and PA confirmation online. If this is not functional, when do you anticipate it will be? If it is functional, when did the functionality begin?	Participating providers with AGP have access to an AGP ASSIST secured website. Through this site they have the ability to submit a request for an authorization and check the status of an authorization. This function has been in place with AGP since June 2006.
AMERIGROUP did not supply Myers and Stauffer with providers' application dates or credentialing dates as requested. AMERIGROUP representatives stated that this information was unavailable. However, DCH routinely receives this information in reports from AMERIGROUP.	Please indicate the method used by AMERIGROUP to track this information and to provide this information to DCH. Please explain why the information was unavailable to Myers and Stauffer. Please submit requested information to Myers and Stauffer as soon as possible.	On 9/25/07, AGP had a conference call with M&S representatives and Marvis Butler and John Upchurch. At that time, we discussed the fact that due to the short implementation timeframes AGP was under during go-live, the application date information would not be widely available for most providers and not at all for any delegated entities. AGP did, however, have the credentialing date available. It was agreed during this conference call that AGP could exclude the application date data element. In our research of the initial query that was

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
		run to produce this file, the credentialing date appears on AGP's file. We are unclear as to why it was not available for viewing by M&S except that maybe that element disappeared somehow during the file transfer from AGP's system to the portal. We have re-run this file and have posted to the portal under the file name "Myers & Stauffer – revised provider file 7-08".
The suspended claims data provided by AMERIGROUP included 32 hospital claims for CHOA with information indicating that the claims were suspended in June 2006.	Please indicate whether these claims have been resolved, and if so, provide the resolution date and explain why the claims appeared in the July 2007 file of suspended claims.	AGP would need the list of 32 claims to respond accurately and completely to this statement. Unable to validate the concern without this information.
A comparison of the provider rate file supplied to Myers and Stauffer by AMERIGROUP to the provider contracts supplied by AMERIGROUP revealed inconsistencies with 14 of the outpatient rates and 1 inpatient rate. Please see list below. Outpatient • Candler Hospital • Chestatee Regional Hospital • Cobb Memorial Hospital	For each facility, please document the rate that you currently have loaded in your system, along with the rate in the provider contract. For rates that have been corrected, please indicate: • The date of correction • Reason for inconsistency	AGP would need the 14 out-patient rates referenced to respond accurately and completely to this statement. Unable to validate the concern without this information.

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
• East Georgia Regional Medical Center • Mountain Lakes Medical Center • North Georgia Medical Center • Northeast Georgia Medical Center • Satilla Regional Medical Center • St Mary's Hospital • Tattnall Community Hospital • Walton Regional Medical Center • Wellstar Cobb Hospital • Wellstar Douglas Hospital • Wellstar Paulding Hospital Inpatient • Hutcheson Medical Center	• Whether all previously submitted claims have been reprocessed/ adjusted for these providers? • If so, was interest paid on the mis-payment amounts? • If no interest was paid or if the claims have not been corrected, please describe when these events will occur.	
According to the data you provided, it appears that two hospital provider contracts required more than 120 days to load based on the difference between the effective date as a participating provider and the date the hospital was loaded into the system as participating (Redmond Regional Medical Center and Emory Johns Creek Hospital).	Please explain why these providers required this amount of time to load as participating providers. Describe any system improvements that were made to correct any problems identified above.	Emory Johns Creek was contracted via Emory hospital prior to the hospital officially being open by Emory. The delay in loading was due to both the opening of the hospital and the hospital obtaining a Georgia Medicaid ID. Redmond Regional Medical Center was a part of the HCA contract. The Health Plan tested the contract on 12/15/2006. They were made par based on an effective date of 12/06/06.

AMERIGROUP GEORGIA MANAGED CARE COMPANY, INC.
RESPONSE to MYERS & STAUFFER REPORT

M&S Report #2 – Hospital Claims		
Area of Concern	**Action Required**	**CMO Response**
		AGP provided weekly reports to DCH on hospital contacting loading due to go live and had previously addressed the questions related to these facilities. The health plan since go live has experienced a 30 -45 day contract load on hospital contracts and does not feel this is an issue any longer. The time frame is based on the complexity of the contract.

M&S Report #3 – Policies and Procedures		
Area of Concern	**Action Required**	**CMO Response**
For the post stabilization requirements listed in section 4.6.2 of contract, policy and procedure documentation was found for one of the five requirements. One of the requirements, 4.6.2.4, appears to be partially met as language for 4.6.2.4.2 and 4.6.2.4.3 was found, but requirement 4.6.2.4.1 was not found. The other three requirements were not found in the documentation provided by AGP.	Please confirm and submit policies that confirm adherence to the requirements of the following sections of the DCH Model contract: 4.6.2.1, 4.6.2.4, 4.6.2.5, and 4.6.2.6.	The following is available in the provider manual: Emergent Admission Notification Requirements AMERIGROUP prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify AMERIGROUP of emergent admissions within one business day. AMERIGROUP utilizes InterQual® and Milliman criterion for review of emergent

	If policies do not exist, please draft and submit to DCH for approval.	admissions. AMERIGROUP Medical Management staff will verify eligibility and determine benefit coverage. AMERIGROUP is available 24 hours a day, 7 days a week to accept emergent admission notification at the National Contact Center at 1-800-454-3730. Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets criteria, an AMERIGROUP reference number will be issued to the hospital. If the notification documentation provided is incomplete or inadequate, AMERIGROUP will not approve coverage of the request, but will notify the hospital to submit the additional necessary documentation. If the Medical Director denies coverage of the request, the appropriate notice of proposed action will be mailed to the hospital, member's primary care provider and/or attending physician and member.
Contract requirement 4.11.1.1.4 states that all Medical Necessity determinations are made in accordance with DCH's Medical Necessity definition as stated in Section	Please confirm and describe why additional components are present.	Need information as to what they are referencing to respond.

4.5.4 The medical necessity definition used by AGP appears to contain components from the GF CMO model contract definition state in Section 4.5.4, however additional components are present.		
Myers and Stauffer was unable to confirm whether the policies of AGP are consistent with the contractual requirements in 4.14.3.4.1, related to proposed actions.	Please confirm if this contract requirement, including effective date, is in your policies and procedures and provide documentation of this policy. If policies do not exist, please draft and submit to DCH for approval.	If AGP previously authorized services, we would not terminate, reduce or suspend. We do not retroactively change the authorization. For a request for continuation of services, AGP follows NCQA and DCH requirements/timeframes to make a determination within 14 days or 72 hours for expedited requests.
Contract language in 4.6.1.4 requires that a CMO base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. Myers and Stauffer was not able to identify policies and procedures for AGP that states coverage decisions for emergency room services are based on the severity of presenting symptoms.	Please confirm if this contract requirement, including effective date, is in your policies and procedures. Please provide documentation of this policy and procedure. If policies do not exist, please draft and submit to DCH for approval.	AGP pays the ER claim regardless of the severity of the presenting systems. Attached is another copy of the AGP reimbursement policy related to non participating providers that relates to ER services.
Myers and Stauffer asked AGP to describe	Please provide additional explanation	AGP responded not applicable as AGP

how the prudent layperson criteria are applied when adjudicating claims and to describe the staff resources and qualifications used in the process. AGP provided the following response: "Not applicable to AGP".	regarding this response, including why a federal regulation would not be applicable to AGP. Submit policies that document how AGP applies the prudent layperson standard. If policies do not exist, please draft and submit to DCH for approval.	pays ER claims regardless of the Diagnosis codes that are billed. AGP does not downgrade ER claims based on non emergent DX codes similar to the other CMOs. Attached another copy of the AGP reimbursement policy related to non participating providers that relates to ER services. AGP needs the M&S claim examples to review to determine whether the area of concern is valid. Our processes do not support that area of concern stated by M&S.
For third party liability claims, AGP does not have information listed for pre-certification requirements related to these types of claims in the documentation submitted to Myers and Stauffer.	Please confirm and describe if this process is in your policies and procedures. Please provide documentation to support this policy and procedure. If policies do not exist, please draft and submit to DCH for approval.	**Need clarification on the area of concern related to pre-certification requirements??**
Regarding recoupment's, stated in 4.10.4.5, criteria were not found in AGPs policies and procedures to address this requirement.	Please confirm if this contract requirement, including effective date, is in your policies and procedures and please describe how it is applied. If policies do not exist, please draft and	Recoupment information is covered in the base contract for providers under section 4.6 Right of Offset (older contracts 5.7) AGP did submit all P & Ps to DCH recently related to recoupements. The P &

	submit to DCH for approval.	Ps can be found on the AGP portal. The process is as follows: Claim Submission Within 90 Days of Service If the health plan pursues a post payment audit or retroactive denial of a claim that was submitted within 90 days of the last date of service or discharge covered by the claim, the following limitations apply: • The provider must be provided with a written notice of the health plan's intent and the specific reason for the audit or claim denial; • The written notice must be delivered within 12 months of the last date of service or discharge covered by the claim; and • The audit or retroactive denial of payment must be completed within 18 months of the last date of service or discharged covered by the claim. The provider must also be notified of any payment or refund due prior to the expiration of the 19 month period. **Claims Submitted After 90 Days of Service** If the health plan pursues a post payment audit or retroactive denial of a claim that

		was submitted after 90 days of the last date of service or discharge covered by the claim, the following limitations apply:
		• The provider must be provided with a written notice of the health plan's intent and the specific reason for the audit or claim denial;
		• The written notice must be delivered within 12 months of the initial submission of the claim;
		• The audit or retroactive denial of payment must be completed the **earlier** of
		  o Within 18 months of the initial submission of the claim; or
		  o Within 24 months of the date of service; and
		• The provider must also be notified of any payment or refund due within the same period of time.

Does AGP have a policy and procedure that outlines the "72 hour rule" criteria in regards to claim adjudication?	Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process. Please also describe how providers have been informed of these policies.	AGP is responding to this question under the assumption that this is being referred to as it relates to "any charges for inpatient services associated with the readmission for the same DRG that occurs within 3 days of discharge from the provider for an earlier admission. Attachment A of a hospital contract addresses readmissions within 3 days of a discharge for the same

		DRG. The provider is responsible for combining the bill and submitting one bill to AGP for payment. If the provider submits 2 separate bills for the same DRG for re admission then AGP will recoup the readmission via the recoupment process called Forager. Notifications would be sent to the provider allowing response, etc following recoupment process on notifications prior to recoupment.
Does AGP have a policy or procedure regarding global charge claims adjudication?	Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process. Please also describe how providers have been informed of these policies.	AGP would need more specifics as to what the question is related to so that an accurate response can be supplied.
Myers and Stauffer was unable to find policies or other documentation describing AGPs process for reprocessing claims when system changes are made that would apply retroactively.	Please describe AGP's policies and procedures when changes are made within the claims processing system for reasons other than provider related causes (e.g. system logic updates, provider rate changes/corrections, or provider contract updates) to ensure any previously submitted claims are reprocessed/adjusted? Is there a process in place to reprocess/adjust the affected claims or	AGP would reprocess claims via the process in place at the Health plan called CAMP. For example, if a provider was placed on an incorrect agreement ID that paid 100% and was corrected to an agreement ID that paid 105%. Then the Provider Data Maintenance Department would notify the CAMP

	does AGP require providers to resubmit claims? If a MMIS correction is made based on provider inquiry, comments, reconsideration, or appeal, is this same change applied to all providers' claims, if applicable. Or, does AGP require other affected providers to resubmit claims?	analyst by placing a note in the CAMP database that a claims report is needed and possible claims need to be reprocessed. The report would outline all applicable claims paid incorrectly (if that is the case) and then AGP would re-process with interest. If identified by the Health Plan then the Health plan would initiate these steps. AGP does not require a provider to resubmit claims for the above issues. Only if the provider incorrectly billed the claim the first time would corrected claims need to be resubmitted. This would be considered a separate issue and not related to payment/system changes.
Myers and Stauffer was unable to confirm functionality of capability for on-line submission of authorization and verification of prior authorization request status.	Please confirm if the following functionality is available to providers on the AGP website: Check status of prior authorization request and submit an authorization request. If this functionality is not available, when do you anticipate it will be? If this functionality is available, when did this begin and please confirm this process is operational and functioning correctly?	Duplicate question. See above. Participating providers with AGP have access to an AGP ASSIST secured website. Through this site they have the ability to submit a request for an authorization and check the status of an authorization. This function has been in place with AGP since June 2006.

Myers and Stauffer did not find policies that address handling of urgent and emergent admissions in the absence of notification.	Is a claim denied if the provider does not provide notification of an emergent or urgent admission in accordance to the said timeframes listed in the provider manual? Is there a comparable notification requirement for emergency services as well? If so, is a claim denied if the provider does not provide notification of emergency services? Please describe AGP's policies and procedures for emergent and urgent care notification. If policies do not exist, please draft and submit to DCH for approval.	If an authorization is not on file for the facility for a given member then the Inpatient Claim will be denied for no authorization. See attached ER policy for non participating providers.
From a review of a sample of contracts between AGP and network providers, it appears that these contracts do not always use the same definition of emergency medical services found in the DCH/CMO contract.	Please explain and provide the rationale for not using the same definition.	Due to negotiations with hospital it may be necessary to negotiate language but in keeping with the same intent. If specific responses are required to the contracts in question please provide the contracts in question and AGP can review to provide any additional clarity if needed.
It appears that for many providers, AGP reimburses providers for emergency medical services based on the CPT billed by the provider. However, for a smaller number of providers, it appears that AGP uses a different methodology, including the	Please explain the rationale for using two different approaches and why the CPT only approach (i.e. reimbursement based on CPT code only) is not used for all providers.	AGP would need examples as previously stated AGP does not downgrade ER billing based on non emergent DX codes. Attached another copy of the AGP

application of the prudent layperson provision for claims with certain diagnoses codes and CPT codes.	Please provide policies that document handling of emergency services. If policies do not exist, please draft and submit to DCH for approval.	reimbursement policy related to non participating providers that relates to ER services.

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
1. The initial Myers and Stauffer claims analyses appear to indicate that many hospital contracts were entered after the contract effective date.	A. Clarify whether this problem only related to the implementation process? B. Describe the steps that have been (or were) taken to ensure that new contracts and/or providers are loaded prior to the effective date of the contract. C. Describe process for monitoring contract loading to ensure that contracts are loaded prior to their effective date.	**1A.** This problem was isolated to the start up activities of the health plan. **1B.** PSHP has improved the process so contracts are loaded prior to the effective date. Process improvements include frequent meetings to discuss contract strategies, date of contract renewals, changes in rates and new contracting prospects. Contract loading is coordinated through a Contract Implementation Manager (CIM) who ensures the required information is received in order to meet the effective date. The contracting goal is to ensure that all contracts are implemented within 45 (not to exceed 60) business days. **1C.** PSHP's Contract Implementation Manager (CIM) and staff monitor the implementation of the contracts through the process described in 1B above and update applicable functional areas of any risks of not meeting the expected timeframe. The CIM is responsible for the testing, validation and approval of contracted rate configuration and provides updates of timeframes, testing results and the possible financial liability if timeframes will are not met. The process is independently audited to validate turnaround time targets are being met.
2. System corrections do not appear to automatically be applied to previously processed claims.	A. Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy changes, eligibility updates, or provider contracts loaded after the effective date). 1. What steps are taken to ensure any previously submitted claims are reprocessed/ adjusted? 2. Are all claims affected by the issue reprocessed/ adjusted or only those claims submitted by the provider who brought the issue to your attention? 3. If you only reprocess/adjust the claims for the provider that brought	**2A.** Claims are re-adjudicated when they are identified as incorrectly paid. Incorrectly paid claims are identified through provider adjustment requests, appeals and Joint Operating Committee meetings. Timely filing requirements are routinely waived and interest is applied to the reprocessed claims. Adjustments are paid back to the date the error occurred. This has been done regardless of whether the root cause of the payment error was PSHP's or the providers'. PSHP is experiencing fewer payment error complaints after completing an initiative to correct provider data files and improve the provider contract loading turn around time. If a trend attributed to a specific error is discovered, it is investigated and corrective action is taken to adjust impacted claims. Beginning July 1, 2008, PHSP will comply with HB 1234, which establishes a 90 day limit for providers to submit batch payment reconsiderations to PSHP. If PSHP identifies payment errors, corrections are made to our systems to appropriately pay the specific claim type going forward. If the provider submits claims for reconsideration within the time limits established by HB 1234, PSHP will review the claims, render a decision and take appropriate action to correct

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
	the issue to your attention, please explain the rationale for this policy.	the root cause. If the reconsideration is approved, we will issue correct payment adjustments for the claims submitted within the time limits established by HB 1234 and pay the mandated 20 percent interest rate.
3. Interest payments do not appear to be applied to claims that are reprocessed to adjust for system or processing errors.	A. Describe your policy for paying interest when claims are reprocessed/ adjusted after a reference file or system update (e.g. corrected authorization, corrected rate file, delayed provider entry, or system logic change). 1. Is interest automatically paid to the provider retroactively to the date of the original submission? 2. If you do not pay interest in these instances, please provide the rationale for not paying interest in these cases.	**3A.** Interest is paid on claims that are adjusted or rekeyed when it is determined that the initial payment or non-payment is a PSHP error. 1. Interest is calculated from the original received date of the claim to the check run date of the adjustment. 2. Interest is not paid when a provider submitted a claim that does not meet clean claim criteria.
4. The initial Myers and Stauffer claims analyses appear to indicate that a significant portion of suspended claims and denied claims are related to authorization issues.	A. Provide your analysis of the reasons/ issues that are leading to these types of denials. B. Describe the steps or corrective actions that are being taken to address these issues.	**4A.** PSHP's root cause analysis indicated these types of denials are mainly caused by user errors and configuration issues. PSHP strives to correct these errors immediately when identified. A complete re-training of all PSHP UM staff occurred at the end of March that resulted in a sharp decline of the error rate. Root cause analysis of error reports and issue remediation continues on a daily basis. **4B.** As of June 23, 2008, we are manually reviewing any system denial for no authorization on file if there is an authorization indicated on the claim. If an authorization is found during the manual review process, the denial is overturned and paid.
5. The initial Myers and Stauffer claims analyses appear to indicate the member was not eligible on the date of service. However, after reviewing the data from the fiscal agent contractor (ACS), it appears that some of these members were	A. Describe your policy and process for handling eligibility updates. Specifically indicate your reconciliation process for identifying and updating previously denied claims.	**5A.** Eligibility files are received daily and monthly from ACS. Eligibility updates are automated and uploaded into Amysis within hours of receiving of the file. In cases where the member record is incomplete or cannot be loaded automatically, the record is manually updated by an Eligibility Specialist. Errors and issue remediation of eligibility spans are not included in the manual updates unless instructed by DCH. At the time the claim is submitted, if the member record does not reflect an active

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
determined by DCH to eligible on the date of service (i.e. a member included in the ACS lock-in file for which the CMO received a capitation payment.		eligibility span for the date of service, the claim will be denied. Providers are instructed to utilize the appeals process for reprocessing previously denied claims. Once a provider submits a formal appeal for the denied claim, analysis is performed to validate the eligibility spans (using both the data received via the 834 file from ACS and the GHP portal). If the member is deemed eligible during dates of service provided, the claim is adjudicated accordingly.
6. It appears from the Myers and Stauffer claims analyses and provider input that monies previously paid under the merged member have, at times, been recouped with a notice indicating the member was not active. These claims often appear to have been denied for timely filing when resubmitted under the new member number.	A. Describe your process for handling merged member records. B. Is the claim history and authorization history transferred to the new member number? C. What steps have been taken to alleviate this issue?	**6A.** If a claim is paid under the incorrect member record, it is recouped, rekeyed and processed under the correct member record. **6B.** Yes, the claims history and authorization history are transferred to the new member number. **6C.** When provided the necessary documentation to identify the members as merged, we recoup payments from the deleted file and reissue payments to the valid member file upon receipt of amended claims. The original submission time frames will be used to release payment of the valid member file
7. Provider complaints regarding ability to submit prior authorization data on-line, along with inability to obtain confirmation of authorization or status of request.	A. Please confirm that online access to prior authorization (PA) information is available to all providers and that they are able to receive PA status information and PA confirmation online. B. If this is not functional, when do you anticipate it will be? C. If it is functional, when did the functionality begin?	**7A.** PSHP's secure web portal allows registered users to submit authorization requests online and obtain the status of the authorization. This feature is available through the reporting function on the secure portal (See attachment of screen shots). Please note providers are not able to see or obtain a status report for authorizations that are phoned or faxed into the plan. See the notations on the bottom of the instructions web page that inform the provider of this fact. **7B.** N/A **7C.** This website functionality has been available since August 2006.
8. The suspended claims data provided by Peach State indicated that approximately 75% of the suspended claim volume was related to provider set-up issues.	A. Describe the steps that have been taken to resolve these issues. B. How long does it take, on average to resolve provider set-up issues (from date of	**8A.** PSHP has completed an audit of executed contracts to ensure that all participating providers are properly loaded into the claims payment system. This contract file review was completed in April 2008. Quality metrics are in place to monitor all contracts loaded to ensure that providers are loaded timely and accurately according to the information provided.

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
	initial notification, to date provider is notified of change and claims pay correctly)? C. In the case of a claim that is suspended due to a provider set-up issue, does Peach State pay interest to the provider?	PSHP has also restructured its provider data department to better coordinate with the contracting department. This reorganization ensures that the process is efficient and that all parties are aware of any opportunities for process improvements. It also identifies any roadblocks in timeliness or accuracy of data loads. In addition, PSHP has assigned a provider representative to work with each hospital and conduct joint operating meetings to resolve identified issues. **8B.** The average turnaround time for correcting provider set-ups varies depending on the type of change/correction required. Demographic corrections/changes are completed within 2 business days of notification (24 hours for urgent requests). Rate/configuration corrections/changes range from one to 30 business days depending on the complexity. Turnaround time is based on the time it takes to configure, test and approve the configuration change. After the change is made, a claims project is developed for claim adjustments which should occur within 30 days of the approved change. As of June 30, 2008, PSHP has 13 open claim projects with an average project age of 6 days. **8C.** Yes, PSHP pays interest on all claims that are suspended due to provider set-up issues.
9. A comparison of the provider rate file supplied to Myers and Stauffer by PSHP to the provider contracts supplied by PSHP revealed inconsistencies with 5 of the outpatient and inpatient rates. Please see list, below: **Inpatient and Outpatient:** • Archbold Medical Center • Calhoun Memorial Hospital • Donaldsonville Hospital • Early Memorial Hospital (Archbold) **Inpatient only:**	A For each facility, please document the rate that you currently have loaded in your system, along with the rate in the provider contract. B. For rates that have been corrected, please indicate: 1. The date of correction 2. Reason for the inconsistency 3. Whether all previously submitted claims have been reprocessed/ adjusted for these providers 4. If so, was interest paid on the	**9A and B.** Please see attached workbook with rates of all hospitals listed, dates of any corrections made, explanation of change, reprocessed claims, and interest paid. PSHP pays interest on all claims that require adjustment for under or non-payments.

Myers & Stauffer Report #2- Hospital Claims Peach State Health Plan

Area of Concern	Action Required	CMO Response
• Grady General Hospital (Archbold) **Outpatient only:** • Berrien County Hospital	mispayment amounts? 5. If no interest was paid or if the claims have not been corrected, please describe when these events will occur.	
10. According to the data you provided, it appears that two hospital provider contracts required more than 120 days to load based upon the difference between the effective date as a participating provider and the date the hospital was loaded into the system as participating. The providers are: • Tift General Medical Center • Taylor Telfair Regional Hospital • Effingham Hosp & Care Center • Gordon Hospital	A. Please explain why these providers required this amount of time to load as participating providers. B. Describe any system improvements that were made to correct any problems identified above.	**10A.** PSHP has improved the process so contracts are loaded prior to the effective date. According to the provider database the following provider contracts were loaded on or prior to the effective date with the exception of Gordon hospital: Tift General Medical Center was entered into the system as par on 9/1/06 Taylor Telfair Regional Hospital was entered into the system as par on 5/4/06 Effingham Hospital & Care Center was entered into the system as par on 5/5/06 Gordon Hospital was entered into the system as par on 3/9/07. **10B.** PSHP has in place a process to monitor and ensure that all contracts are loaded prior to the effective date. Please see process in question **1B.**

POLICIES AND PROCEDURES- PEACH STATE

11. The DCH Model Contract states in 4.3.3.2.19, the contractor must include a description for utilization policies and procedures in the member handbook. Myers and Stauffer were not able to confirm that PSHP had this description in the member handbook.	A. Please provide documentation, including effective date, showing the inclusion of this material in the member handbook. B. If this material is not in the handbook, please describe reasons for not including and submit a plan with timeframes for inclusion in member handbook.	**11A and B.** The Member Handbook has been revised. [See attached utilization verbiage that will appear in the enhanced Member Handbook which was just recently approved by DCH.] This revised document will be printed the week of July 7 and be distributed in August 2008.
12. For the post-stabilization requirements listed in section 4.6.2 of contra t (including 4.6.2.1-4.6.2.4), Myers and Stauffer was unable to locate policy and procedure	A. Please confirm and submit policies that confirm adherence to the section 4.6.2 (in its entirety) of the DCH Model contract.	**12A.** Policies are in place. [See attached GA.UM.05 Timeliness of UM decisions.] **12B.** N/A

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Area of Concern	Action Required	CMO Response
documentation for any of the required elements.	B. If policies do not exist, please draft and submit to DCH for approval, along with a plan for implementation.	
13. PSHP's policy for their contracted providers requires the provider to waive their rights to an administrative law hearing while participating with the plan. This appears to be contrary to the requirements set forth in the Georgia Model contract in 4.9.7.6.	A. Please confirm and describe why this approach is used and why it is in compliance with the DCH contract.	**13A.** The PSHP policies and procedures changes were made and PSHP began advising providers they may request an administrative law hearing when an outcome of a provider complaint is adverse to the provider. [See attached the version of policies sent on July 1, 2008 to DCH for approval and provider complaint outcome letter.]
14. PSHP has timelines for submittal of notification of emergency services, but Myers and Stauffer was unable to locate language that the contractor shall not refuse to cover an emergency service based on the failure of the provider to notify the contractor, PCP, or DCH of member's screening and treatment within said timeframes, as stated in 4.6.1.7.	A. Please confirm if this contract requirement, including effective date, is listed in your internal policies and procedures. B. Please provide documentation for this policy and procedure, along with description of how your system assures payment in this scenario.	**14A.** Yes, the contract requirement and effective date is in our internal policies**.** **14B.** The Emergency Services Policy, GA.UM.12, provides documentation of this. [See attached.] There is system configuration to accommodate payment of emergency services as the benefits require.
15. Notification of emergent or urgent inpatient admissions in PSHP provider documentation was not consistent. The provider manual states notification is required within 2 business days while the prior authorization list states within 24 hours or next business day.	A. Please confirm the correct timeframe for notification of an emergent inpatient authorization. B. Submit corrected policies and provider manual to reflect the correct time frames.	**15A.** The correct timeframe is next business day. **15B**. All UM policies are consistent with next business day. [See attached GA.UM.05 Timeliness of UM Decisions-revised.] The PSHP Provider Manual revision was submitted July 1, 2008 to DCH for approval. [See attached revised page 26 of PSHP Provider Manual which was submitted.]
16. Is there information in policies and procedures not provided to Myers and Stauffer that outline "72 hour rule" criteria in regards to claims adjudication?	A. Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process.	**16A.** The 72 hour rule applies to outpatient and diagnostic services, as well as admissions that occur within 72 hours of discharge from an inpatient admission. The claims system is configured to global (deny) the service being billed when there are subsequent dates of service submitted that are within 72 hours of the discharge date of an inpatient claim.

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Area of Concern	Action Required	CMO Response
	B. Please also describe how providers have been informed of these policies.	**16B**. Our standard hospital contract language lists the 72 hour verbiage. This is how providers have been informed of this policy.
17. Myers and Stauffer was unable to find any policies regarding global charge claim adjudication.	A. Please indicate whether there are policies and procedures not provided to Myers and Stauffer regarding global charge claims adjudication? B. Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process. C. Please also describe how providers have been informed of these policies.	**17A.** All relevant policies and procedures were provided based on Myers and Stauffer's requests. **17B.** The categories of service include surgeries and emergency department services. There is system configuration to accommodate this requirement **17C**. The Provider Manual, pages 58, 59, 62 and 72 describe global periods as they apply to surgeries and emergency department services.
18. Myers and Stauffer was unable to find policies or other documentation describing PSHP's process for reprocessing claims when system changes are made that would apply retroactively.	A. Please describe PSHP's policies and procedure when changes are made within the claims processing system for reasons other than provider related causes (e.g. system logic updates, provider rate changes/ corrections, or provider contract updates) to ensure any previously submitted claims are reprocessed/ adjusted? B. Is there a process in place to reprocess/ adjust the affected claims or does PSHP require providers to resubmit claims? C. If a MMIS correction is made based upon a provider inquiry, comments, reconsideration, or appeal, is this same change applied to all other providers'	**18A.** Claims are re-adjudicated when they are identified as incorrectly paid. Incorrectly paid claims are identified through provider adjustment requests, appeals and Joint Operating Committee meetings. Timely filing requirements are routinely waived and interest is applied to the reprocessed claims. Adjustments are paid back to the date the error occurred. This has been done regardless of whether the root cause of the payment error was PSHP's or the providers'. PSHP is experiencing fewer payment error complaints after completing an initiative to correct provider data files and improve the provider contract loading turn around time. If a trend attributed to a specific error is discovered, it is investigated and corrective action is taken to adjust impacted claims. Beginning July 1, 2008, PSHP will comply with HB 1234, which establishes a 90 day limit for providers to submit batch payment reconsiderations to PSHP. If PSHP identifies payment errors corrections are made to our systems to appropriately pay the specific claim type going forward. If the provider submits claims for reconsideration within the time limits established by HB 1234, PSHP will review the claims, render a decision and take appropriate action to correct the root cause. If the reconsideration is approved, we will issue correct payment adjustments for the claims submitted within the time limits established by HB 1234

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Area of Concern	Action Required	CMO Response
	claims, if applicable, or does PSHP require other affected providers to resubmit claims?	and pay the mandated 20 percent interest rate.
19. Myers and Stauffer were unable to confirm website functionality to either submit or check the status of an authorization request.	A. Please confirm if the following functionality is available to providers on the Peach State Health Plan website: check status of prior authorization request and submit an authorization request. B. If this functionality is not available, when do you anticipate it will be? C. If this functionality is available, when did this begin and please confirm this process is operational and functioning correctly?	**19A.** Peach State's secure web portal allows registered users to submit authorization requests online and obtain the status of the authorization. This feature is available through the reporting function on the secure portal [See attachment of screen shots.] Please note providers are not able to see or obtain a status report for authorizations that are phoned or faxed into the plan. See the notations on the bottom of the instructions web page that inform the provider of this fact. **19B.** N/A **19C.** This website functionality has been available since August 2006.
20. Myers and Stauffer did not find policies that address handling of urgent and emergent admissions in the absence of notification.	A. Is a claim denied if the provider does not provide notification of an emergent or urgent admission in accordance to the said timeframes listed in the provider manual? B. Is there a comparable notification requirement for emergency services as well? If so, is a claim denied if the provider does not provide notification of emergency services? C. Please describe PSHP's policies and procedures for emergent and urgent care notification. D. If policies do not exist, please draft and submit for DCH approval.	**20A.** The claim is denied for no authorization if the provider does not provide the notification for an inpatient admission in accordance to the said timeframes listed in the provider manual. **20B.** Emergency services do not require notification/authorization. The claim will pay. **20C.** PSHP does not require notification/authorization for emergent /urgent care. **20D.** Policies are in place and have been approved by DCH.

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21. From a review of a sample of contracts between PSHP and network providers, it appears that these contracts do not always use the same definition for emergency medical services found in the DCH/CMO contract. Furthermore, many of these contracts do not use the term “prudent layperson”.	A. Please explain and provide the rationale for not using the same definition.	**21A.** All contracts have the Medicaid product attachment which contains the "prudent layperson" and “emergency services” definitions that are found in the DCH/CMO contract. [See attached PSHP Medicaid Product Attachments for contracts reviewed.]
22. In some contracts between PSHP and network providers, PSHP uses its own listing of approved emergency services after the first year of the contract with the provider. Furthermore, it appears that payment of the claims are sometimes based upon the diagnosis list when the claim is paid, and at times based upon the diagnosis list used when the services are rendered. It appears that PSHP reserves the right to modify its diagnosis list ICD-9 codes at anytime and at other times must have provider approval to do so.	A. Please explain and provide the rationale for using different lists of presumptive emergency diagnoses between the first and second year of the contract and the criteria for modification. In addition, please explain and provide the rationale for using the payment date instead of the service date to determine which presumptive list is used and why this appears to vary among providers.	**22A.** PSHP has not modified the ICD-9 list. We are using the same list that was originally provided by DCH.

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Area of Concern	**Action Required**	**CMO Response**
1. The initial Myers and Stauffer claims analyses appear to indicate that many hospital contracts were entered after the contract effective date.	Clarify whether this problem only related to the implementation process? Describe the steps have been (or were) taken to ensure that new contracts and/or providers are loaded prior to the effective date of the contract. Describe process for monitoring contract loading to ensure that contracts are loaded prior to their effective date.	In some cases noted, providers contracted with WellCare on a retroactive basis and requested retroactive effective dates. WellCare accommodated most of these provider requests and adjudicated claims as appropriate. As a result, contracts were loaded after the agreed upon effective date. As a matter of policy, WellCare conducts an extensive credentialing process for contracting hospitals to ensure that each facility meets NCQA requirements, federal and state regulations for services delivery, quality (i.e. JCAHO) and licensing. During the Go-Live process, many hospitals delayed execution of contracts until several days prior or after the Go-Live effective date. In these cases, providers were advised they would receive 100% of the Medicaid payment rate and were provisionally credentialed (based on instruction and approval from the Department of Community Health) until such time all credentialing information was received and processed In order to assure provider

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Area of Concern	**Action Required**	**CMO Response**
		participation, WellCare added the provider per their instruction. WellCare's policy is to load provider contracts with effective dates of coverage the first of the following month after the provider has been approved by the Credentialing Committee to ensure accurate payment.
2. System corrections do not appear to automatically be applied to previously processed claims.	Describe your policy for handling changes that are made within the system (e.g. system logic updates, provider rate changes/corrections, retro-active policy changes, eligibility updates, or provider contracts loaded after the effective date). • What steps are taken to ensure any previously submitted claims are reprocessed/adjusted? • Are all claims affected by the issue reprocessed/adjusted or only those claims submitted by the provider who brought the issue to your attention? • If you only reprocess/adjust the claims for the provider that brought the issue to your attention, please explain the rationale for this policy.	Systems updates due to policy modifications are applied prospectively with appropriate notice to participating providers. Please note that our provider agreements allow a 45-day timeframe after receipt of notice to implement any rate/modifications stipulated by DCH. If an adjustment is identified for claims submitted, WellCare adjusts all claims impacted for the adjustment. If a provider advises of a adjustment requirement, WellCare will adjust all claims identified.

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Area of Concern	**Action Required**	**CMO Response**
3. Interest payments do not appear to be applied to claims that are reprocessed to adjust for system or processing error.	Describe your policy for paying interest when claims are reprocessed/adjusted after a reference file or system update (e.g. corrected authorization, corrected rate file, delayed provider entry, or system logic change). • Is interest automatically paid to the provider retroactively to the date of original submission? • If you do not pay interest in these instances, please provide the rationale for not paying interest in these cases.	WellCare adheres to the requirements stipulated in its agreement with DCH as well as Georgia law regarding payment of interest. Interest payments of 18% apply in the event the CMO fails to adjudicate (i.e. process) a clean claim within the claims process deadlines [i.e. 15 days]. This penalty by law applies to the speed of payment of a clean claim and does not apply in instances where system updates are applied; authorizations are waived to accommodate provider requests, etc. WellCare's agreement with DCH provides further clarity on this point: Section 4.16.1.8 states, "Not later than the fifteenth (15th) business day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO plan Web Site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the

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Area of Concern	**Action Required**	**CMO Response**
		Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO plan shall complete processing of the Claim within fifteen (15) Business Days. Section 4.16.1.14 states further, "The Contractor shall assume all costs associated with Claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's span of control. 23.4.1.3 Failure to comply with the Claims processing standards as follows: 23.4.1.3.1 Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year; 23.4.1.3.2 Failure to process

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		and finalize to a paid or denied status ninety-nine percent (99%) of all Clean Claims within thirty (30) Business Days of receipt during a fiscal year; and 23.4.1.3.3 Failure to pay Providers interest at an eighteen percent (18%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines. Based on the provisions within our agreement and Georgia statute, our interest payment methodology is compliant in that interest payments are not required provided the claim is adjudicated within the 15-day timeframe.
4. The initial Myers and Stauffer claims analyses appear to indicate that a significant portion of suspended claims and denied claims are related to authorization issues.	Provide your analysis of the reasons/issues that are leading to these types of denials. Describe the steps or corrective	Although WellCare provided significant training, information and materials early on, certain providers failed to obtain authorizations for required services. We believe these

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Area of Concern	**Action Required**	**CMO Response**
	actions that are being taken to address these issues.	provider failures were due in part to a lack of knowledge of WellCare's policy and the fact providers willingly provided services without obtaining proper approvals, i.e. Health Departments, non-par facilities, etc. WellCare has and continues to educate providers regarding authorization requirements for services rendered to members and has seen a significant reduction in the number of claims denied due to lack of authorization. During September thru October 2006 WellCare held Provider Summit meetings across all regions of Georgia. Providers were sent invitations to the summits and RSVP to the meetings. The materials for the summits, including all the questions presented in the meetings, were published and sent via fax, to providers. These activities were in addition to making provider handbooks and other communications available on our website. We also participated in the Hometown Health conference calls to educate rural

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		facilities on our authorization requirements. WellCare continued to publish communications on-line (banner messages) relating to clarification on authorization rules and continues to publish these clarifications on an ad hoc basis.
5. The initial Myers and Stauffer claims analyses appear to have identified claim denials that indicate the member was not eligible on the date of service. However, after reviewing the data from the fiscal agent contractor (ACS), it appears that some of these members were determined by DCH to be eligible on the date of service (i.e., a member included in the ACS lock-in file for which the CMO received a capitation payment).	Describe your policy and process for handling eligibility updates. Specifically indicate your reconciliation process for identifying and updating previously denied claims.	We believe these issues are related to the member merge and audit process conducted by DCH and the CMO's. Member retro-activity is a common process in managed care, particularly with new programs. WellCare's policy is to reimburse providers for services rendered to eligible members based on coverage guidelines stipulated by DCH, WellCare medical management policies and operational procedures. As part of the reconciliation process, WellCare processes member additions and deletions during the end-of-month process and weekly as eligibility data is provided to the plan. Eligibility updates are provided to all delegated vendors on a daily and weekly basis.

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		As a matter of routine, WellCare does not reprocess individual claims denied due to eligibility changes unless requested by the provider. It should be noted that during the identified audit period, there were a significant volume of membership changes due to an on-going eligibility audit conducted jointly by the Plans and DCH. As a result, WellCare paid and denied a significant volume of claims where eligibility was retroactively assigned to the plan after submitted claims were denied.
6. It appears from the Myers and Stauffer claims analyses and provider input that monies previously paid under the merged member have, at times, been recouped with a notice indicating the member was not active. These claims often appear to have been denied for timely filing when resubmitted under the new member number.	Describe your process for handling merged member records. Is the claim history and authorization history transferred to the new member number? What steps have been taken to alleviate this issue?	WellCare initially recouped payments during the clean up process on duplicate members as it was unclear the retro terminations were actually duplicate member clean up IDs. As identified, WellCare coordinated payments with providers in instances where recoupments were made, but eligibility indicated that providers could/should be reimbursed for services. In many instances, WellCare over-rode timely filing requirements with providers to ensure payment due to member merge and eligibility changes.

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Area of Concern	**Action Required**	**CMO Response**
7. Provider complaints regarding ability to submit prior authorization data on-line, along with inability to obtain confirmation of authorization or status of request.	Please confirm that online access to prior authorization (PA) information is available to all providers and that they are able to receive PA status information and PA confirmation online. If this is not functional, when do you anticipate it will be? If it is functional, when did the functionality begin?	Physicians can submit and check the status of authorizations via the web. This functionality was made available in October, 2007 and is fully functional. It should be noted that only ordering physicians may submit and validate status of authorizations for their patients.
8. The claims data provided to Myers and Stauffer by WellCare appears to indicate that no interest payments have been made by WellCare to Georgia Medicaid hospital providers.	Please confirm whether WellCare has made interest payments to Georgia Medicaid hospital providers. If interest was paid, please provide interest data and explain why the data was not provided as requested. If interest has not been paid, please explain why claims that appear to be clean were not paid interest when the claims were adjudicated more than 15 days after submission (e.g. claim numbers: 237942840, 243374438, and 238717964).	Interest payments have been made by WellCare for hospital services. A summary of the interest payments made to facilities is provided in the attached schedule. Interest checks are sent monthly to providers along with an EOB that provides every claim number for which interest was paid.
9. The suspended claims data provided to Myers and Stauffer by WellCare appears to indicate that over	Please provide an updated status of the suspended claims provided in the	The data supplied represents our efforts to pull all claims in the system

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150,000 claims with billed charges in excess of $600 million remained in suspense status as of November 2007. The suspend dates range between June 2006 and November 2007.	data you sent to Myers and Stauffer, explain why the volume of claims is so high for that period, and describe in detail how WellCare will ensure that the volume of suspended claims does not reach this level in the future and that claims in the file will be properly and promptly adjudicated. Provide a plan of action to adjudicate any of these claims that remain in a suspense status. Please also describe how, and provide assurances that if all the claims in the file were to be adjudicated and paid WellCare would financially cover that volume of claims.	as of June 30, 2007. While the snapshot does accurately represent claims in the system not in a finalized status, it also includes subsequent updates to those claims as the data was not pulled until November 2007. The only way to have obtained a true picture of the system on June 30, 2007 would be to take a snapshot on June 30, 2007. In reviewing these claims, we can see that the subsequent posting dates after June 30, 2007 had to do with audits, overpayment recoupments or adjustments that transpired in the following few months.
10. According to the data you provided, it appears that two hospital provider contracts required more than 120 days to load based on the difference between the effective date as a participating provider and the date the hospital was loaded into the system as participating. The providers are: • DOUGLAS HOSPITAL • KENNESTONE HOSPITAL • PAULDING HOSPITAL • WELLSTAR COBB HOSPITAL • WINDY HILL HOSPITAL	Please explain why these providers required this amount of time to load as participating providers. Describe any system improvements that were made to correct any problems identified above.	As a matter of policy, WellCare conducts an extensive credentialing process for contracting hospitals to ensure that each facility meets NCQA requirements, federal and state regulations for services delivery, quality (i.e. JCAHO) and licensing. During the Go-Live process, many hospitals delayed execution of contracts until several days prior to or after the Go-Live effective date. For

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• AUGUSTA HOSPITAL • MEMORIAL HOSPITAL • MEMORIAL NORTH PARK HOSPITAL • WEST GEORGIA MEDICAL CENTER		example, WellStar Medicaid contract was not executed by both parties until 5/30/06, yet the effective date was 6/1/06. WellCare's policy is to load provider contracts with effective dates of coverage the first of the following month after the provider has been approved by the Credentialing Committee to ensure accurate payment. We adopted a process whereby contractors use a more prospective effective date that allows for credentialing and loading of contracts prior to the actual contract effective date. Finally, if a hospital, like WellStar is a delegated credentialed entity, we must complete a Delegated Credentialing review/approval before the contract would be finalized and providers assigned to the facility could be loaded.
11. According to the data you provided, it appears that two hospital providers required more than 100 days to credential based on the difference between the application date and the credentialing date you	Please explain why these providers required this amount of time to credential.	This question appears to be a duplicate of #10. Please refer to #10 response.

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provided. The providers are AUGUSTA HOSPITAL and MEMORIAL NORTH PARK HOSPITAL.	Describe any system improvements that were made to correct any problems identified above.	

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Area of Concern	**Action Required**	**CMO Response**
12. Contract requirement 4.3.3.2.24, in Member Handbook Requirements section of the DCH Model contract, which contains several requirements related to emergency room services, it does not appear that WellCare expressly states in their member handbook that prior authorization is not required for emergency services.	Please confirm and provide documentation that WellCare has met this requirement.	WellCare's policy stipulates that ER services don't require prior authorization. In fact, our handbook instructs members to go directly to the emergency room in case of an emergency. The WellCare member handbooks were reviewed and approved by DCH prior to distribution to members. WellCare can update the member handbook to expressly indicate prior authorization is not required for ER.
13. It does not appear that WellCare included hours of operation for a prior authorization and pre-certification telephone hotline in the documentation supplied to Myers and Stauffer. The contract between DCH and WellCare requires that the hours of operation must be included in the policies and procedure, as stated in 4.9.5.5 of the DCH Model contract.	Please confirm and provide documentation that WellCare has met this requirement.	WellCare does include hours of operation for prior authorization and pre-certification telephone hotline in its policy and procedures. Please refer to Customer Service Requirements Policy and Procedure.
14. Myers and Stauffer was unable to confirm	Please confirm if these contract	WellCare policies are consistent with

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whether the policies of WellCare are consistent with the contractual requirements in 4.14.3.4.1 and 4.14.3.4.5, which are related to proposed actions.	requirements, including effective date, are listed in your internal policies and procedures. Please provide documentation regarding these policies and procedures.	contractual requirements. Please refer to the Adverse Determinations/Proposed Action P&P.
15. Contract language in 4.6.1.4 requires that a CMO base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson. Myers and Stauffer was not able to identify policies and procedures for WellCare that states coverage decisions for emergency room services are based on the severity of presenting symptoms.	Please confirm if this contract requirement, including effective date, are listed in your internal policies and procedures. Please provide documentation of this policy and procedure. If policy does not exist, please submit plan for completing and implementing policy that addresses these requirements.	WellCare conforms with section 4.6.1.4 of the contract regarding emergency room services. Please refer to our Emergency Services - Institutional P&P provided for your reference
16. WellCare has timelines for submittal of notification of emergency services, but Myers and Stauffer was unable to locate language that the contractor shall not refuse to cover an emergency service based on the failure of the provider to notify the contractor, PCP, or DCH of member's screening and treatment within said timeframes, as stated in 4.6.1.7.	Please confirm if this contract requirement, including effective date, is listed in your internal policies and procedures. Please provide documentation for this policy and procedure, along with description of how your system assures payment in this scenario.	Please refer to Emergency Services - Institutional P&P. This policy outlines those scenarios when a claim is denied. Emergency room services do not require notification. Services provided in an ER setting are paid based upon prudent layperson criteria, as stipulated in the CMO agreement.

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Area of Concern	**Action Required**	**CMO Response**
		As noted above, notification is <u>not</u> required for emergent or urgent care services performed in an emergent or urgent care setting. Emergent or urgent <u>admissions</u> require the submission of a written plan of care within 24 hours of the admission for payment. The plan of care should include: • Diagnosis, symptoms and complaints for the admission • A description of the functional level of the individual • Medication or treatment orders • Diet and activity levels • Plans for hospital course • Plans for discharge The plan of treatment should be multi-disciplinary and include the attending physician as well as nursing staff. Section 8, of our hospital manual (Utilization Management) describes our policies and procedures regarding

Myers & Stauffer Report #3 – Policies & Procedures – WellCare Area of Concern	Action Required	CMO Response
		emergent admissions
17. WellCare emergency services policy states that the company provides payment for any screening examination to determine if an emergency medical condition exists, however, language or similar language to that in 4.6.1.8 was not found in this or other available policies.	Please confirm if this contract requirement, including effective date, is listed in your internal policies and procedures and provide documentation of this policy.	As a matter of policy, WellCare provides payment for any screening examination to determine if an emergency medical condition exists. This is provided in our triage payment or included in the claim payment if the claim is determined to meet emergency criteria. Our current Policy and Procedure for ER services is silent on this contract language; as a result, we will modify our policies to expressly state this requirement. It should be noted, in most cases, a claim does not contain information specifying the member was sent to the ER by their physician. As such, these cases are handled during the reconsideration process when the hospital sends medical records with documentation indicating member sent to ER by a physician for ER services.
18. For third party liability claims WellCare does not have information listed for pre-certification requirements related to these types of claims in the documentation submitted to Myers and Stauffer.	Please confirm and describe if this process is in your policies and procedures. Please provide documentation to	WellCare does acknowledge other carrier authorizations/pre-certifications when considering a TPL claim for payment. However, since the auto-adjudication process

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	support this policy and procedure.	does not review other carrier policies, if a provider received a denial for services, they would need to file an appeal with the appropriate documentation from the Primary Insurance plan. Current Coordination of Benefits Policy states WellCare does acknowledge the member's benefit coverage (which takes into consideration prior authorization/pre-certification rules).
19. Does WellCare have a policy or procedure that outlines the "72-hour rule" criteria in regards to claim adjudication?	Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process. Please also describe how providers have been informed of these policies.	Yes, WellCare has a policy that outlines the "72-hour rule. Please refer to Inpatient Hospital Services P&P.
20. Myers and Stauffer was unable to find any policies regarding global charge claim adjudication.	Please indicate whether there are policies or procedures not provided to Myers and Stauffer regarding global charge claims adjudication? Please describe the categories of service for which this policy applies, and the specific criteria that are used in the claim adjudication process. Please also describe how providers	WellCare does have a policy regarding global charge claim adjudication. Please refer to Maternity Services P&P. Our policy on global OB payment was reviewed with our Provider Relations staff who shared with the Providers during orientation meetings. Providers are made aware of these policies through our provider relations staff and training.

Myers & Stauffer Report #3 – Policies & Procedures – WellCare Area of Concern	Action Required	CMO Response
	have been informed of these policies.	
21. Myers & Stauffer was unable to find policies or other documentation describing Wellcare's process for reprocessing claims when system changes are made that would apply retroactively.	Please describe Wellcare's policies and procedures when changes are made within the claim processing system for reasons other than provider related causes (e.g. system logic updates, provider rate changes/corrections, or provider contract updates) to ensure any previously submitted claims are reprocessed/adjusted? Is there a process in place to reprocess/adjust the affected claims or doesWellCare require providers to resubmit claims? If a MMIS correction is made based on a provider inquiry, comments, reconsideration, or appeal, is this same change applied to all providers' claims, if applicable, or does WellCare require other affected providers to resubmit claims?	WellCare instituted an internal process within 60 days of implementation involving corporate and market team members reviewing claims/configuration issues on a weekly basis. During the process, the team identifies and corrects any errors and pulls reports to assess scope of impact and determine course of actions to reprocess claims. In certain cases, the issues presented are provider specific, and therefore, all claims for all providers are not necessarily reprocessed.
22. Myers & Stauffer were unable to confirm website functionality to either submit or check the status of an authorization request.	Please confirm if the following functionality is available to providers on the WellCare website: check status of prior authorization request and	WellCare provides on-line authorization functionality. Physicians may submit and check the status of authorizations via the web.

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	submit an authorization request. If this functionality is not available, when do you anticipate it will be? If this functionality is available, when did this begin and please confirm this process is operational and functioning correctly?	This functionality was made available in October, 2007 and is fully functional. It should be noted that only ordering physicians may submit and validate status of authorizations for their patients.
23. Myers & Stauffer did not find policies that address handling of urgent and emergent admissions in the absence of notification.	Is a claim denied if the provider does not provide notification of an emergent or urgent admission in accordance to the said timeframes listed in the provider manual? Is there a comparable notification requirement for emergency services as well? If so, is a claim denied if the provider does not provide notification of emergency services? Please describe Wellcare's policies and procedures for emergent and urgent care notification, including whether claims are denied if notification is not received. If policies do not exist, please draft and submit to DCH for approval.	WellCare does provide policies for handling of urgent and emergent admissions.WellCare requires a written plan of care for all emergent or urgent admissions within 24 hours of the admission for payment. Notification is not required for emergency services performed in the emergency room. Services are processed and paid based on WellCare ER services payment criteria. The written plan of care must be submitted in order to receive payment. As noted above, notification is not required for emergent or urgent care services performed in an emergent or urgent care setting. Emergent or urgent admissions require the

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		submission of a written plan of care within 24 hours of the admission for payment. The plan of care should include: • Diagnosis, symptoms and complaints for the admission • A description of the functional level of the individual • Medication or treatment orders • Diet and activity levels • Plans for hospital course • Plans for discharge The plan of treatment should be multi-disciplinary and include the attending physician as well as nursing staff. Section 8, of our hospital manual (Utilization Management) describes our policies and procedures regarding emergent admissions
24. From a review of a sample of contracts between Wellcare and network providers, it appears that these contracts do not always use the same definition for emergency medical services found in the DCH/CMO contract.	Please explain and provide the rationale for not using the same definition.	WellCare's contracts should contain the same/consistent language regarding emergency medical services definition. There are instances where payment for

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Area of Concern	**Action Required**	**CMO Response**
		emergency room services may differ (PLP criteria versus case rates or fee schedule payments). However, the definition for emergency care services should be consistent. If possible, please provide specific examples of variance.